

**AIDS AND THE CRIMINAL JUSTICE  
SYSTEM: AN AUSTRALIAN PERSPECTIVE**

**by**

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## **ABSTRACT**

### **AIDS and the Criminal Justice System:**

#### **An Australian Perspective**

This thesis argues that the role of the criminal law in response to the emergence of AIDS should be a limited one and that this is largely dictated by the goals and processes of the criminal law. The research also isolates questions which need to be addressed and changes that need to be considered to present law, procedure and policies in light of AIDS, within public health departments and the various arms of the criminal justice system.

The first chapter describes HIV/AIDS infection, compares it epidemiologically with other infectious diseases and examines the present and predicted global epidemiology of the disease. Chapter two focuses on the aims of the criminal law simpliciter and in the context of AIDS. Chapter three analyses how and if so, how well, existing criminal law provisions could be applied to particular circumstances of HIV transmission. In chapter four pre-existing public health legislation that penalises the transmission of communicable diseases is examined in the context of AIDS. In this chapter the political and societal processes that led to the adaptation of pre-existing legislation to cope with HIV/AIDS are considered.

Chapters five through seven focus on how the public health and criminal justice systems have adapted in light of HIV/AIDS infection. The theme behind this part is to examine how individual interests are threatened by the powers held by particular individuals and to strike a balance between competing interests. Chapter five considers the breadth of the powers of public health officials to implement procedures designed to control the spread of communicable diseases. Chapter six considers how the criminal justice system will impact upon both HIV-infected persons and their victims during the criminal process. In particular, the chapter examines changes that have or should be made to investigatory and trial procedures. Chapter seven considers the risk of transmission of HIV within the prison system and then canvasses the legal implications of a variety of procedures that have been or could be introduced with the aim of preventing the spread of HIV/AIDS within Australian prisons. The dominating throughout these two chapters is to consider whether the criminal justice system can make an effective and worthwhile contribution to the overall strategy aimed at checking progression of the AIDS epidemic. Chapter eight contains a general conclusion.

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*Venereal Disease Ordinance* (1956)

## **Regulations**

*Public Health (Infectious and Notifiable Diseases) Regulations Amendment* (1983)  
*Public Health (Infectious and Notifiable Diseases) Regulations* (1991)  
*Remand Centres Regulations* (1976)

## **NORTHERN TERRITORY**

### **Proclaimed Acts**

*Anti-Discrimination Act* (1992)  
*Bail Act* (1990)  
*Crimes Compensation Act* (1982)  
*Criminal Code* (1983)  
*Criminal Code (Amendment Act )* (1992)  
*Criminal Law (Conditional Release of Offenders) Act* (1978)  
*Evidence Act* (1939)  
*Justices Act* (1980)  
*Mental Health Act* (1980)  
*Misuse of Drugs Act* (1990)  
*Notifiable Diseases Act* (1981)  
*Police Administration Act* (1978)  
*Police and Police Offences Ordinance* (1923)  
*Prisons (Correctional Services) Amendment Act* (1985)  
*Prostitution Regulation Act* (1992)  
*Summary Offences Act* (1923)  
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*Quarantine (General) Regulations* (1988)  
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**CANADA**

*Criminal Code* R.S.C. 1980. c C-46

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*Offences Against the Person Act* (1861)  
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*Sexual Offences Act* (1967)  
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*Vagrancy Act* (1898)

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*Homosexual Law Reform Act* (1986)  
*Crimes Act* (1961)

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## **INTRODUCTION**

The emergence of the Human Immunodeficiency Virus (HIV) more commonly known by its advanced stage of infection, the Acquired Immune Deficiency Syndrome (AIDS), has reaffirmed that disease is a complex phenomenon. To understand it one must be cognisant not only of its biological dimensions but also of its social construction. History reveals that society turns to the 'lawmaker' to unravel the social ramifications of disease. However, the history of previous legal encounters with infection has not always been an uplifting one. People panic. Out of panic come irrational and ineffective policies and worse, harsh and oppressive laws.

Since the emergence of HIV in 1981, the ramifications of HIV/AIDS infection have arisen in many areas of the law, including the criminal law, public health law, employment law, medical law, insurance law, the law relating to public education, immigration and quarantine, civil and human rights. There is no doubt that, 'AIDS has posed many challenging and sometimes unique problems for the law'.<sup>1</sup> Uncertainties and debate which have flourished within the sphere of medicine with respect to the disease have their associated parallels within the law. AIDS elucidates the difficulties the law encounters when efforts are made to regulate its transmission in light of the paucity of knowledge about the disease. Indeed, the law's response to AIDS has varied world-wide as have the views of academic writers in the fields of law, humanities and medicine.

Although it is true to say that AIDS has produced a great deal of literature, up until the late 1980s in Australia, few writers focused on the criminal law and the criminal justice system.<sup>2</sup> Since 1990 the approach has still been to

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<sup>1</sup> Watson, L., and Godwin, J., *The AIDS Law and Civil Liberties Project*, New South Wales, AIDS Council of New South Wales Inc., 1988, at p. 1.

<sup>2</sup> The article by Howie, R. N., and Webb, P. J., 'The Legal Responses to AIDS' (1985) 18(1) *Australian Journal of Forensic Sciences*, 44-55 was one of the papers presented at the first Australian National AIDS Conference held in 1986. Neither the second nor third National AIDS Conferences dealt with AIDS and the Criminal Law or within the criminal justice system as a whole, in any detail. A plenary session of the third Conference in 1988 was devoted to AIDS in prisons and another section dealt briefly with the role of police and corrective services departments. Since 1990, other organisations have exhibited a renewed interest in the criminal law in the context of HIV/AIDS. This is reflected by the release of various discussion papers prepared by the Intergovernmental Committee on AIDS such as 'Legal Issues Relating to AIDS and Intravenous Drug Use' and 'HIV/AIDS Prevention, Homosexuality and the Law', Canberra, Department of Community Services and Health, 1991. An *HIV/AIDS Legal Guide* was first published in 1991 and contained brief chapters on criminal transmission of HIV and prisoners and the criminal justice system (Godwin, J., Hamblin, J., Patterson, D., and AFAO, *Australian HIV/AIDS Legal Guide*, Sydney, Federation Press, 1991). These chapters were updated and enlarged in the 1993 edition (Godwin, J.,

cover particular areas to the exclusion of others. For example, the issue of AIDS in prisons,<sup>3</sup> the general application of current criminal law provisions to AIDS<sup>4</sup> and the question of decriminalisation of IV drug use<sup>5</sup> have received the most attention. By 1994 it appears that little research or in-depth analysis has been conducted within Australia into the purposes to be served by criminalisation and the effect of HIV on both infected persons or those at risk of infection during the pre-trial and trial processes and post conviction. Although one Australian commentator has written on the efficacy of the criminal law in curbing the spread of the virus,<sup>6</sup> none have considered the far-reaching implications of criminalisation for the system of criminal justice as a whole. The 1989 Federal Government *National HIV/AIDS Strategy*<sup>7</sup> is silent on the use of punitive measures for culpable behaviour and contains only fleeting references to the criminal justice system. This is surprising, given that the criminal justice system selects and filters a moderate number of persons at high-risk for transmission of the virus, such as IV drug users. More recently, the Working Party of the Intergovernmental Committee on AIDS implied that criminal liability for transmission of HIV is an inappropriate response to controlling the pandemic.<sup>8</sup> A decision of this kind should have been precipitated by a thorough analysis of the aims of criminalisation made with a less than adequate examination of the overriding aims of the criminal law in Australia.

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Hamblin, J., Patterson, D., Buchanan, D., *Australian HIV/AIDS Legal Guide*, Sydney, Federation Press, 1993).

<sup>3</sup> This has been highlighted by the Australian Institute of Criminology 'HIV/AIDS in Prisons' Conference held Melbourne, November 19-20, 1990 which covered the area of HIV infection in Prisons in some depth. Selected conference papers and other articles are referred to in chapter seven.

<sup>4</sup> Bronitt, S., 'Criminal Liability for the Transmission of HIV/AIDS' (1992) 16 *Criminal Law Journal*, 85-93. This selectivity is also common to many articles in the US in the area including: Hermann, D. H. J. 'Criminalising Conduct Related to HIV Transmission' (1990) 9 *Saint Louis University Public Law Review*, 351; Puhlman, M. E., 'The AIDS Challenge Continues: Should Pennsylvania's Criminal Law Take on the Challenge?' (1992) 30 *Duquense Law Review*, 283.

<sup>5</sup> The specific works which focus on the question of decriminalising IV drug use in light of AIDS are considered in chapter two, at fn 94.

<sup>6</sup> Bronitt, *supra* note 4.

<sup>7</sup> Commonwealth of Australia, *National HIV/AIDS Strategy: a policy information paper*, Canberra, Australian Government Publishing Service, 1989; and a further paper:, Commonwealth of Australia, *National HIV/AIDS Strategy: 1991-1993, 1994-1996* Canberra, Australian Government Publishing Service, 1993.

<sup>8</sup> IGCA, *Legislative Approaches to Public Health Control of HIV Infection*, Canberra, IGCA, 1991, para. 3.3, at p. 24.

In the early years of the AIDS epidemic in Australia (1985-1987), as in the rest of the western world, the issue was canvassed as to whether the criminal law ought to be invoked to deal with the emerging AIDS 'crisis'. The prevailing sentiment by law-makers and other interested groups at that time was that the criminal law was not an appropriate tool by which to control the spread of AIDS.<sup>9</sup> This decision was made with a less than adequate examination of Australian criminal law itself or its underlying rationale. In fact, responses in the criminal law sphere and in some instances in public health law, which has been used as an alternative means by which to impose restrictions on individual behaviour, have been dictated more by political convenience than careful informed choice among the alternatives available.

In 1989 Neave predicted that 'as increasing numbers of people are infected from a range of groups, there is likely to be increasing pressure on existing [public health] policies combined with support for more repressive strategies'.<sup>10</sup> The prediction was correct because the 1990s has seen a resurgence of interest in the application of the criminal law to HIV transmission. There is no doubt that it has been prompted by the continued spread of the disease, the number of HIV-infected persons passing through the criminal justice system and the perceived increase in criminal activity involving threats of transmission of HIV, particularly syringe-related activity.<sup>11</sup> In the United States since 1988, these same factors have led to an increasing number of jurisdictions passing specific legislation criminalising HIV transmission.<sup>12</sup>

The resurgence may be due also, in part, to the lack of a uniform Australian definitive statement one way or the other about whether the criminal law should intervene. It may be that interested writers concluded that the current response to HIV/AIDS in Australia was inadequate in that it failed to recognise the State's responsibility to protect the public from harm; and, to appreciate the extent to which self-protection from HIV infection is not always an option available to some sexual partners, for example, victims of sex crimes,

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<sup>9</sup> See Carr, A., 'AIDS: The Australian Response', *Meeting the Challenge*, Canberra, Australian Government Publishing Service, 1986, 50-55. Kirby, M., 'AIDS Legislation - Turning up the Heat?', (1986) 60 *Australian Law Journal*, 324-332. McGuirl, M. C., and Gee, R. N., AIDS: 'An Overview of the British, Australian, and American Responses', (1985) 14(1) *Hofstra Law Review*, 107-135. Howie and Webb, *supra* note 2.

<sup>10</sup> Neave, M., 'AIDS and Women in the Sex Industry - Legal Approaches to Public Health' (1989) 12(4) *Community Health Studies*, 423-430, at p. 423.

<sup>11</sup> this perception being most commonly perpetuated through the media.

<sup>12</sup> Harris, K. 'Death at First Bite: A Mens Rea Approach to Determining Criminal Liability for Intentional HIV transmission' (1993) 35 *Arizona Law Review*, 237-264, lists 16 States where legislation renders it a criminal offence to transmit HIV sexually.

prostitutes and women in general, particularly those from certain cultural backgrounds where male dominance is unquestionable.

Therefore, the question of whether to impose criminal responsibility for the transmission of HIV rekindles the debates about the proper limits of coercive state action, about the interrelationship between law and morality and the appropriate interrelationship or nexus that ought to be developed between criminal law and public health law. Few people have described the conditions that must be satisfied before an activity becomes eligible for punishment. In the absence of any sound Australian literature on the point, solutions to every kind of social problem are frequently sought from the criminal justice system. When we refuse to criminalise we are wrongly accused of trying to suppress a problem. We suffer from overcriminalisation as a result of this and the politics of trying to keep the peace with the multiplying number of societal groups.

As the criminal law is the strongest force by which the State can control individuals, there needs to be justification for its use as a method of control. The philosophical basis for criminalising behaviour which transmits HIV must be addressed. The likely efficacy of criminalisation and the application of current laws to new problems will also arise for discussion. These questions have been considered in the past with respect to homosexuality, prostitution and drug use. All of these activities now carry the attendant risks of HIV infection and it remains to be seen whether this new dimension changes any former conclusions. In this thesis, the underlying assumptions behind imposing criminal liability are analysed to see if they justify the intrusion of the criminal law to prevent the spread of disease. This leads into a debate over the aims of the criminal law: the enforcement of morality as against the prevention of harm to others.

In considering these matters one needs to take into account the fact that in Australia like other liberal democratic societies, the value of individual autonomy has increased across all branches of the law including criminal law and public health law. This increase in private autonomy rights will create problems for the intervention of the criminal law in HIV/AIDS and must be taken into account when formulating policy.

With respect to public health law, the emergence of the disease has seen the application by Australian State and Territory governments of inappropriate and archaic public health measures to a new disease with allegations of resulting 'rights' violations. Criminal law and public health law legislators have to work together on a policy to curb the spread of HIV infection.

Criminalisation should not serve to undermine the public health response. If it does, then we must examine whether the gains are worth it. The policy should attempt to balance public health interests of the community against potentially conflicting individual rights. Therefore, the overriding public health aim must be to control the spread of the virus without actively discriminating between societal groups and implementing counterproductive measures. Uniform and effective action is preferable to haphazard and piecemeal amendments to legislation that are dictated by public sentiment.

It is not only public health administrators who must determine medical facts to resolve legal controversies. The participants within the various arms of the criminal justice system face similar roles, as the presence of AIDS within the criminal justice system as a whole cannot be ignored. This disease has resulted in, and has provided the impetus for questioning the appropriateness of prior practices and fostering the refinement or even changes in some of the procedures within the criminal justice system. These include the procedures adopted by police and public health officials when HIV-infected persons are arrested or detained, the consideration whether HIV-infection is regarded as a mitigating factor for sentencing purposes and whether custodial sentences should be imposed on HIV-infected persons. Many of the issues raised by this thesis, for example, whether to order HIV blood testing of a sexual offender as a condition of bail, have not yet been addressed by Australian law makers or become the source of any guiding judicial precedents.

The underlying framework adopted in this thesis could be described as a combined medico-moral-political analysis of how disease affects society. From this there springs three main aims. Accordingly, the first aim is to consider how the politics of AIDS and of diseases and social problems of the past (and present) directly or indirectly underlies the way that governments, legislatures and courts have acted in the context of HIV/AIDS. This is examined by comparing the response to HIV/AIDS *vis-a-vis* diseases of the past. The real issues are about morals, sexual etiquette and individual freedom and how the criminal justice system and the public health system fall in relation to each of those issues. The second is to provide support for the view that the criminal law should have a limited role in preventing the spread of the epidemic. Instead primary responsibility should be placed on public health departments to detect and manage recalcitrant sufferers. The final aim is to consider how the criminal justice system has adapted or should adapt in light of the presence of AIDS. This necessitates an analysis of the key areas which specifically impact on an HIV-infected person and his or her victim.

This thesis is divided into eight chapters which fall into two notional parts. The first part contains a philosophical analysis of criminalisation. The other part is a practical examination of the justice likely to be meted out to HIV-infected persons and their victims. In truth, these parts are interconnected because any case for criminalisation cannot be analysed in the abstract but must be grounded within the system as it operates at a particular time or as it is planned to operate in the future.

The first chapter describes HIV/AIDS infection, compares it epidemiologically with other infectious diseases and examines the present and predicted global epidemiology of the disease. This chapter sets the stage for considering if the magnitude of the problem justifies the intervention of the criminal law. Chapter two focuses on the aims of the criminal law simpliciter and in the context of AIDS. Chapter three analyses how and if so, how well, existing criminal law provisions could be applied to particular circumstances of HIV transmission. In chapter four pre-existing public health legislation that penalises the transmission of communicable diseases is examined in the context of AIDS. In this chapter the political and societal processes that led to the adaptation of pre-existing legislation to cope with HIV/AIDS are considered. The arguments for and against the establishment of an HIV specific offence are also debated in this chapter.

Chapters five through seven focus on how the public health and criminal justice systems have adapted in light of HIV/AIDS infection. The theme behind this part is to examine how individual interests are threatened by the powers held by particular individuals and to strike a balance between competing interests. Chapter five considers the breadth of the powers of public health officials to implement procedures designed to control the spread of communicable diseases. Chapter six considers how the criminal justice system will impact upon both HIV-infected persons and their victims during the criminal process. In particular, the chapter examines changes that have or should be made to investigatory and trial procedures. Chapter seven considers the risk of transmission of HIV within the prison system and then canvasses the legal implications of a variety of procedures that have been or could be introduced with the aim of preventing the spread of HIV/AIDS within Australian prisons. The dominating throughout these two chapters is to consider whether the criminal justice system can make an effective and worthwhile contribution to the overall strategy aimed at checking progression of the AIDS epidemic. Chapter eight contains a general conclusion.

## CHAPTER 1

# **GLOBAL EPIDEMIOLOGY AND MEDICAL ASPECTS OF AIDS**

### **1. INTRODUCTION**

The Acquired Immune Deficiency Syndrome (AIDS) has contributed to the death-rate in developed and developing countries in a dramatic way. It is of pandemic rather than epidemic proportions. The legal problems associated with this pandemic are vast and varied. In this chapter, the extent of the problem of AIDS and the Human Immunodeficiency Virus (HIV) will be addressed by focusing on the global epidemiology of the disease. This must be gleaned before deciding whether to implement laws. The medical aspects of infection with HIV, and the progression to AIDS, will be outlined. A brief comparison will be made between the epidemiology of HIV infection and other communicable diseases. Such a comparison is included because past legislation enacted to control the spread of communicable diseases will be relevant to the formulation of AIDS legal policy.

### **2. THE GLOBAL EPIDEMIOLOGY OF AIDS**

According to World Health Organisation (WHO) statistics, as at December 31 1993, 193 countries or territories had reported a total of 851,628 cumulative AIDS cases. The total figure included 435,978 in the Americas (North and South America with 339,250 cases in the United States), 103,402 in Europe, 301,861 in Africa and 4,828 in Australia.<sup>7</sup>

These figures cover certain stages of AIDS or HIV infection only and there may be many more instances of HIV infection not recorded by official statistics. In December 1992, WHO estimated that the cumulative global total of AIDS cases was more than 2.5 million.<sup>8</sup> As infection with HIV will progress to AIDS and AIDS will lead to death (as there is no cure for infection with HIV), confirmed figures of HIV-infection can be treated as the likely future death-rate from AIDS.

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<sup>7</sup> *Wkly Epidemiol Rec*, 1994, 69:5-8.

<sup>8</sup> Department of Health, Housing and Community Services, *Communicable Diseases Intelligence Bulletin*, 1993, 17/8:161-165.



Only a number of medical conditions satisfy the surveillance or case definition of AIDS accepted for statistical purposes. For example, not all indicator diseases of HIV-infection form part of the case definition set by the Centre for Communicable Diseases in Atlanta, Georgia in the United States and endorsed by WHO. Changes made to the case definition in 1987, 1988 and 1993 resulted in many conditions previously excluded being included with a resulting increase in cases satisfying the case definition. The changes in definition and identification methodology have generally been followed in Australia<sup>9</sup> and replace the old classification system (using categories such as AIDS 'A' and AIDS 'B' to represent AIDS and Aids Related Complex (ARC) respectively) that had been recommended by the AIDS Task Force in 1985. The old system was found to have '... little use as a prognostic guide.'<sup>10</sup> These changes to the case definition have also affected the accuracy of the predictions made in early years as to the course of the pandemic.<sup>11</sup>

Given the rudimentary or non-existent nature of reporting mechanisms in developing countries the figures presented ought not be treated as conclusive indicators of HIV-infection in those countries. For example, the WHO figure for AIDS cases in Thailand in July 1991 was 106. However, reports from the Prime Minister's Office suggested that in reality 300,000-400,000 persons at that time were infected with HIV.<sup>12</sup> Further, in many countries including Australia it must be recognised that estimates are understated because often deaths from HIV/AIDS will be attributed to other conditions to avoid the stigma and prejudice associated with the disease.

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<sup>9</sup> Neither Australia nor Europe agreed to follow the 1993 changes to extend the AIDS case definition on the basis of the percentage of CD4+ T-lymphocyte count. In the United States, adults and adolescents with diagnosed HIV infection who have a CD4+ T-lymphocyte count of less than 200  $\mu$ l of blood or a CD4+ T-lymphocyte percentage of less than 14, with or without the diagnosis of disease(s) indicative of a decrease in cell-mediated immunity, are included in the definition (CDC, '1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults', *MMWR*, 1992, 41 (No. RR-17):1-19). As such Australia only agreed to extend the case definition to include clinical conditions such as pulmonary tuberculosis, recurrent tuberculosis and invasive cervical cancer. The reluctance of Australia and Europe to follow the changes in full may result in some perceived under-reporting in the recorded case figures for AIDS in Australia and Europe (Kaldor, J., and Hall, R., 'The United States Centre for Disease Control 1993 revised AIDS case definition: Implications for Australia' *Australian HIV Surveillance Report*, 1993, 9(2): 8-9).

<sup>10</sup> Whyte, B., and Cooper, D., 'The Surveillance Definition of the Acquired Immunodeficiency Syndrome and the Clinical Classification of Infection with the Human Immunodeficiency Virus Type 1', *Med J Aust* 1988, 149:368-373, at p. 370.

<sup>11</sup> Chin, J., 'Public Health Surveillance of AIDS and HIV Infection', *Bull Who* 1990, 68 (5): 529-536.

<sup>12</sup> Editorial, 'Poor Man's Plague', *The Economist*, September 21 1991, 21-24.

Although estimates cannot be made with any degree of certainty<sup>13</sup> and depend on the statistical models adopted,<sup>14</sup> there have been many predictions about the likely rate of increase of the disease. In 1988 Mann stated 'the curve of reported cases has been rising relatively slowly to date compared to the expected rise in the next five years'.<sup>15</sup> These comments were based on the belief of WHO that between five and ten million people were then infected with HIV and that 10-30% of those infected would develop AIDS five years hence. In 1988, the Foreign and Commonwealth Office in London suggested that 'since the number of AIDS cases in a country reflects infection rates from two to eight years previous; the current rate of HIV infection is more important than the current number of cases, in estimating the future development of the disease'.<sup>16</sup> On this basis in 1990 WHO stated that by the year 2000, more than half of the predicted 5 million cases would develop into AIDS.<sup>17</sup> In 1992, this prediction was revised by Dr Mann, formerly of WHO. Taking into account that more than thirteen million people had already contracted HIV prior to February 1992, Mann predicted that AIDS was 'spinning out of control' and will have claimed the lives of 24 million people world-wide by the year 2000 leaving 120 million people infected with HIV.<sup>18</sup> As an example of how uncertain the predictions are, WHO disagreed with Mann alleging that at most only 40 million people will be infected by the year 2000.<sup>19</sup>

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<sup>13</sup> Especially since 1993 when an Australian study cast doubt on the validity of the HIV-antibody tests on which the WHO predictions, in particular, are based (reported by Hodgkinson, N., 'New Doubts over AIDS Infection as HIV Test Declared Invalid', *The Sunday Times*, August 1 1993, pp. 1-2). Dax in reviewing a number of studies on the specificity of the Western Blot test admits that in the early days of testing the number of different criteria used to interpret Western Blot results led to a confusion in interpreting the Western Blot. She suggests that as a supplemental test to distinguish true from false positive screening results, the Western Blot, with the application of strict interpretation criteria, is highly specific and 'still the stalwart in anti-HIV testing strategies' (Dax, E., 'HIV Western Blot test' [letter] *Med J Aust* 1994, 160: 808).

<sup>14</sup> Solomon, P. J., Wilson, S. R., Swanson, C. E., and Cooper, D. A., 'Predicting the course of AIDS in Australia', *Med J Aust* 1990, 153:386-392.

<sup>15</sup> Foreign and Commonwealth Office, 'AIDS: The World Summit and Its Outcome', Background Brief, London, September, 1988, at p. 1.

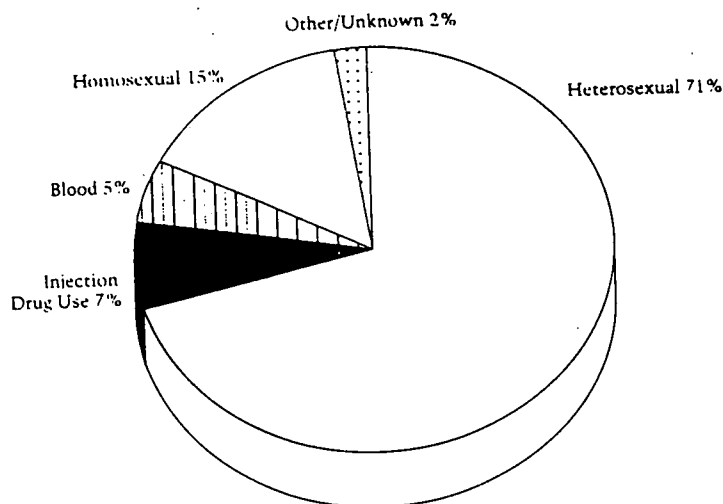
<sup>16</sup> *Ibid*, at p. 1.

<sup>17</sup> Reported in Chin, J., Sato, P.A., and Mann, J. M., 'Projections of HIV Infections and AIDS cases to the year 2000', *Bull Who*, 1990, 68(1):1-11.

<sup>18</sup> Mann, J., 'AIDS-The Second Decade: A Global Perspective', in *J Infect Dis* 1992, 165, fn 245.

<sup>19</sup> Kirby, M., 'AIDS and the Law' (1993) 21 *Commonwealth Law Bulletin*, 350-366 at p. 355.

The greatest increase in AIDS cases has occurred in Africa and Central America. Between January 1989 and February 1990 AIDS cases in Africa rose from 20,905 <sup>20</sup> to 41,512 <sup>21</sup> and in the Central Americas (including the Caribbean) from 10,172 to 15,163. More astounding is the rise from 41,512 AIDS cases to 92,957 cases in Africa between February 1990 and July 1991 <sup>22</sup> and then from 92,957 cases to 144,863 between July 1991 and April 1992. <sup>23</sup> The greatest increase has been seen in the period from December 1992 to December 1993 where AIDS cases soared from 211,032 to 301,861. <sup>24</sup> This huge increase over a short time in Africa is believed to be due to a high basic reproductive rate, high rates of sexual partnership (prostitution), high rates of other sexually transmitted diseases and 'chronic activation of the immune system by other infectious diseases'. <sup>25</sup> One would also have to concede that the better organisation of reporting in Africa would have been of some effect. The contribution of the African epidemic to the overall world total is reflected indirectly by the proportion of heterosexuals infected in Figure 1. <sup>26</sup>



<sup>20</sup> *Communicable Diseases Intelligence Bulletin*, 1989, 2:2-3.

<sup>21</sup> *Communicable Diseases Intelligence Bulletin*, 1990, 6:13-15.

<sup>22</sup> *Communicable Diseases Intelligence Bulletin*, 1991, 15/20:360-363.

<sup>23</sup> *Wkly Epidemiol Rec*, 1992, Vol. 67(14).

<sup>24</sup> *Wkly Epidemiol Rec*, 1993, 68:9-11 and 1994, 69:5-8.

<sup>25</sup> Skegg, D. C. G., 'Heterosexually acquired HIV infection', *BMJ*, 1989, 298:401-402. This view is supported by later research in the area: Anderson, R. and May, R., 'Understanding the AIDS Pandemic', *Sci Am* 1992, 266(5): 20.

<sup>26</sup> Adapted from GAPAC (The Global AIDS Policy Coalition) Estimate and Projections of Adult HIV infections and AIDS 1992-1995 to be found in Mann, J. M., Tarantola, D. J. M., Netter, T. W. (eds) *AIDS in the World 1992*, Cambridge, Harvard University Press, 1992, p. 33.

As can be seen from Figure 1, the impact of the pandemic of AIDS on the world population is felt more within certain societal groups such as homosexuals, bisexuals, heterosexuals, IV drug users, transfused blood or blood product recipients and haemophiliacs. In Africa the main route of transmission of HIV is by heterosexual contact <sup>27</sup> and it is likely that the African cases are largely responsible for the large proportion of heterosexual cases reflected in the pie-chart. This was not always the case. In the early years of the pandemic, the pie-chart would have contained a section corresponding in size to the current heterosexual group but it would have represented homosexual transmission. In this respect, the 1990s has seen a transformation of the disease across societal groups that has largely been dictated by the receipt of transmission rates from developing countries.

By contrast, the impact of heterosexual transmission has been slow in developed countries. A transmission-type analysis of AIDS cases in the United States still reveals that homosexual transmission is paramount. For example, 58% of the total AIDS cases until June 1993 have resulted from homosexual sex, 23% from intravenous drug use, 6% from homosexual sex and drug use combined, and 6% from heterosexual sex (of which sex with heterosexual drug users represents the greatest number of cases). <sup>28</sup> Similarly in Australia, figures as at December 31 1993 reveal that 77.9% of AIDS cases have resulted from homosexual/bisexual contact with only 5.7% of cases represented by the combination of homosexual conduct and IV drug use and 6.5% of cases resulting from heterosexual contact. There is a further figure of 2.6% attributed to the combination of heterosexual sex and IV drug use. <sup>29</sup>

In all countries the age group between 20-40 years is most commonly infected. <sup>30</sup> Figures released in Australia, listing AIDS cases by age at date of diagnosis to June 30 1993, reveal that out of the total 4,258

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<sup>27</sup> Quinn, T. C., Mann, J. M., Curran, J. W., and Piot, P., 'AIDS in Africa: an epidemiological paradigm', *Science*, 1986, 234:955-963. See also Reid, E., 'AIDS in Africa' (1988) 10/2 *African Studies Association of Australia and The Pacific Newsletter*, 3-8 where an early estimate is provided that 80-85% of AIDS cases in Africa occur as a result of heterosexual contact (at p. 5) and see also Anderson and May, *supra* note 19.

<sup>28</sup> 'Update - acquired immune deficiency syndrome 1993' *MMWR*, 1993, 42(28):547-551.

<sup>29</sup> National Centre in HIV Epidemiology and Clinical Research, *HIV Surveillance Report*, 1994, 10/2:9, Table 1.2.

<sup>30</sup> For evidence of this in Africa see Reid, *supra* note 21, p. 4. In Australia, this is set out in any edition of *Communicable Diseases Intelligence Bulletin* that lists AIDS and HIV cases by age category. In the United States, statistical reports from the Centers for Disease Control and Prevention appeared formerly in *AIDS/HIV Rec* published by Bio-Data and presently on a quarterly basis in *AIDS*. In Europe, the World Health Organisation, *Wkly Epidemiol Rec* provides evidence that the 20-40 year age group is commonly infected.

cases, 2,526 or 59.3% fall in the 20-39 year age group. Of the 2,786 deaths that have occurred in Australia from AIDS, 1,502 or 53.9% have occurred in that age group.<sup>31</sup> These figures represent infected persons that fulfill the case definition of AIDS. Even in the HIV infection category, the mean age at diagnosis from 1985-1993 for males is 32.4 years and for females 30.5 years.<sup>32</sup> For developing countries, this age selectivity is more devastating because the educated elite is affected, pushing back the entire continent's economic and social development.<sup>33</sup> A number of developed countries also report that there are more young lives lost by virtue of AIDS than by motor vehicle accidents or suicide.<sup>34</sup> In the United States it has been calculated that the years of potential life lost before the age of sixty-five increased by 9.9% for HIV between 1989 and 1990.<sup>35</sup> In 1992, HIV became the leading cause of death for men aged between 25-44 years in the United States.<sup>36</sup>

As at October 1988, Australia was ranked 24th in the world in terms of notified AIDS cases.<sup>37</sup> By December 1992 Australia was ranked 21st.<sup>38</sup> It is useful to hypothesise on the accuracy of Mann's predictions for Australia between 1992 and 1995. Mann predicted that by January 1st 1992 28,000 Australian/Oceania populations would be infected with HIV, with 4,500

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<sup>31</sup> *Australian HIV Surveillance Report*, 1993, Vol. 9/4: 8, Table 4.3.

<sup>32</sup> *Australian HIV Surveillance Report*, 1993, 9/4: 5, Table 2.1.

<sup>33</sup> Rollason, R., 'A One-world crisis', McPherson, J., (ed) in *AIDS and Compassion*, Canberra, St. Mark's, 1988, at p. 105.

<sup>34</sup> Valleron, A.J., 'Demographic Consequences of Mortality from AIDS in France in 1990: AIDS Ahead of Suicide and Close to Motor Vehicle Deaths', in Papers, *First International Conference on the Global Impact of AIDS*, 1988. The study by Marzuk, P.M., Tierney, H., Tardiff, K., et al, 'Increased risk of suicide in persons with AIDS', *JAMA* 1988, 259: 1333-1337, concludes that an increasing number of suicides are committed by young men suffering from AIDS. See also Kristal, A.R., 'The Impact of the Acquired Immunodeficiency Syndrome on Patterns of Premature Death in New York City', *JAMA*, 1986, 255:2306-2310. By 1986, AIDS was the eighth most important cause of loss of life in the United States (Mann, J., 'AIDS Epidemiology, Prevention and Control', Reid, E., (ed), *WHO/Australian Inter-Regional Meeting on AIDS*, Canberra, Australian Government Printer, 1987, 33-56, at p. 50). In 1992 it was still the eighth most important cause ('Update: Mortality Attributed to HIV Infection Among Persons Aged 25-44 years US - 1991-1992' *MMWR* 1993, 42(28): 869-772 at p. 869).

<sup>35</sup> CDC, 'Years of Potential Life Lost Before Age 65 and 85 - United States 1989-1990' *MMWR*, 1992, 41(18):313-315.

<sup>36</sup> *MMWR* *supra* note 28.

<sup>37</sup> Adams, A. I., 'IV International Conference on AIDS - Implications for Australia', *Mod Med Aust* 1988, 47-52.

<sup>38</sup> *Wkly Epidemiol Rec*, 1993, 68:9-11.

AIDS cases.<sup>39</sup> Given the fact that 15,679 Australians were found HIV positive at the National AIDS Registry by December 31 1992<sup>40</sup>; that Australia is one country out of twenty-three in the Oceania region (with New Zealand and Papua New Guinea the only other countries providing significant case numbers); and, that Mann's estimates build-in a certain component for under-reporting, the prediction may be accurate. This is further supported by examining the AIDS<sup>41</sup> cases. By December 1992 3,615 AIDS cases had developed in Australia and 348 AIDS cases in New Zealand. These figures are not far off the predicted total of 4,500 for the entire region. By 1995, Mann predicted there will be 40,000 cases of HIV infection including 11,500 AIDS cases in the Australian/Oceania region.<sup>42</sup> By mid-1994 it appears that this estimate will not materialise. Figures for December 31 1993 reveal that there are 5,303 AIDS cases in the region with 4753 and 413 represented by Australia and New Zealand respectively. In addition, there have been 19,256 notifications of HIV infection recorded.<sup>43</sup> This rate will have to double to reach Mann's prediction by 1995. Such a result would be unlikely given the current progression rate of the disease in this region. There is no suggestion that the remaining countries in the Oceania region will see the dramatic increases over short periods that has characterised the epidemic in Africa and some Asian countries.

When comparing the reported AIDS case rate as of December 1992 in United Kingdom of 6,510 cases with that in Australia of 3,615 cases and taking into account the fact that the United Kingdom as of 1992 had a population of approximately 57.9 million<sup>44</sup> compared to 17 million,<sup>45</sup> the ratio of cases per one hundred thousand of the population is higher in

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<sup>39</sup> GAPAC (The Global AIDS Policy Coalition) Estimate and Projections of Adult HIV infections and AIDS 1992-1995 *supra* note 20, Table 2.3A, p. 885. Apparently, Mann did not include any South East or North East Asian countries in the category 'Oceanic' since there were separate categories for these areas.

<sup>40</sup> *Australian HIV Surveillance Report*, 1992, 8(suppl 1): 16, Table 3.3.

<sup>41</sup> In this context the writer is referring to those cases that fulfil the CDC case definition of AIDS as adopted by Australia.

<sup>42</sup> GAPAC Estimate and Projections of Adult HIV infections and AIDS 1992-1995 to be found in Mann, *et al*, *supra* note 20, Table 2.3B, at p. 885.

<sup>43</sup> *Australian HIV Surveillance Report*, 1994, 10/2: 31, Table 7.1.

<sup>44</sup> The population of the United Kingdom as of December 1992 when the last official census taken was 57,998 million (Office of Population Census and Survey, London, reported in *Annual Abstract of Statistics*, London, HMSO, 1994, Table 2.1, at p. 4).

<sup>45</sup> Australian Bureau of Statistics, *Australian Demographic Statistics*, June quarter 1992, Canberra, Australian Bureau of Statistics, 1993.

Australia. In fact, figures reveal that Australia has a case ratio of 2.5/100,000 whereas the United Kingdom has a ratio of 2.2/100,000.<sup>46</sup> At first glance the conclusion could be drawn that HIV infection represents a significant threat to the health and the demographics of Australia. However, it is the rate of increase that is important and it appears that in Australia the progression rate has slowed. For example, in the United Kingdom between December 1992 and December 1993 the number of AIDS cases has increased from 6,510 to 8,115 whereas in Australia, the increase for the corresponding period has been from 3,615 to 4,828 cases.

By 1989, the most important and serious implication of the AIDS pandemic for developed countries was the emerging impact of AIDS within the heterosexual population and IV drug users.<sup>47</sup> It was feared that the criminal justice system would be selecting and filtering large numbers of persons at-risk for HIV. Drew and Taylor in 1988 stated that there were approximately 9,000 regular IV drug users in Australia who could potentially die from AIDS contracted by 1990. They also estimated there were between 175,000 and 500,000 occasional IV drug users who were at high risk of becoming infected.<sup>48</sup> The rate may be further exacerbated by the increasing number of narcotic drugs such as designer drugs, amphetamines and crack that are injected.<sup>49</sup>

A study by Haverkos and Edelman in the United States reveals that the heterosexual spread of HIV is slow, in the absence of IV drug usage and genital ulcerative disease.<sup>50</sup> This link may explain why there has been a low rate of transmission of HIV from males to their spouses. The theory has also been confirmed by European studies.<sup>51</sup> In addition, Canada, United

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<sup>46</sup> *Wkly Epidemiol Rec*, *supra* note 32.

<sup>47</sup> Haverkos, H.W., and Edelman, R., 'The Epidemiology of Acquired Immunodeficiency Syndrome Among Heterosexuals', *JAMA*, 1988, 260:1922-1929, Carballo, M., and Rezza, G., 'AIDS, Drugs Misuse and the Global Crisis' in Strang, J., and Stimson, G. V., (ed), *AIDS and Drug Misuse*, London, Routledge, 1990, 16-26 at 18.

<sup>48</sup> Drew, L., and Taylor, V., *The Second AIDS Epidemic: Spread via Needle-Sharing to the General Community: A Review*, Canberra, Commonwealth Department of Health, 1988.

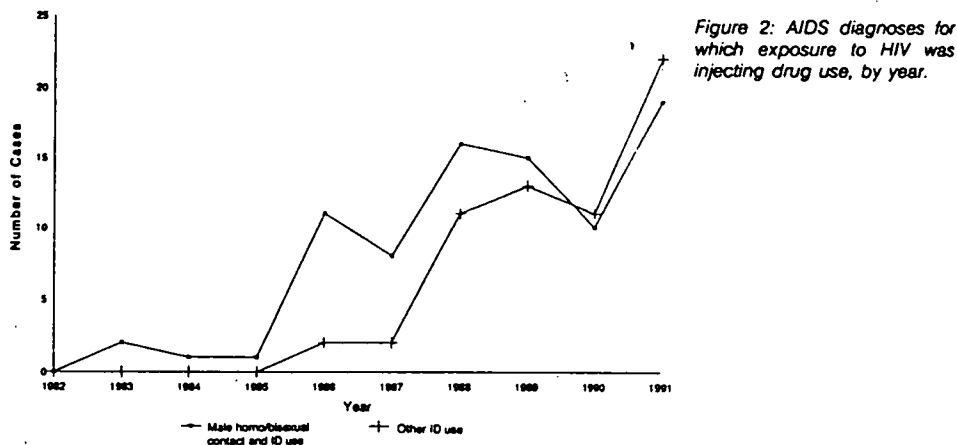
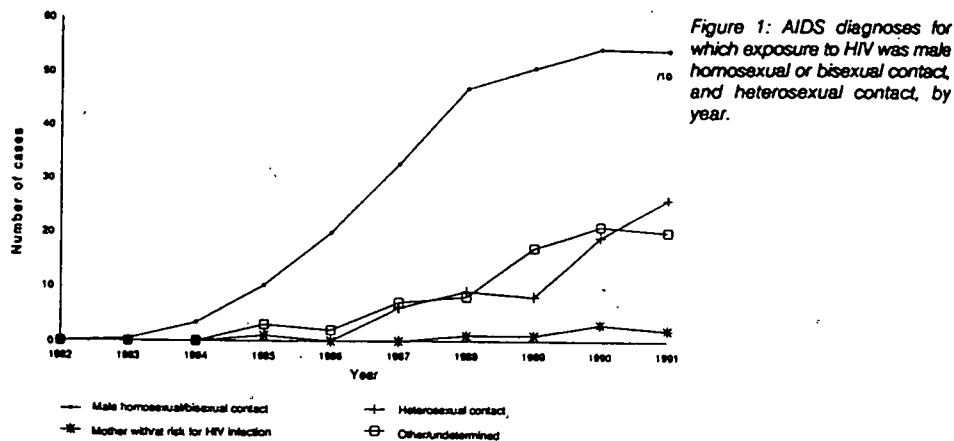
<sup>49</sup> Des Jarlais, D., *et al* 'Crack Use and Multiple AIDS Risk Behaviours', *J AIDS*, 1991, 4:446. Hall, W., and Hando J., *Amphetamine Use Among Young Adults in Sydney, Australia*, Sydney, Drug and Alcohol Directorate of New South Wales, 1993.

<sup>50</sup> Haverkos and Edelman, *supra* note 41, 1922-1929.

<sup>51</sup> Confirmed by WHO Collaborating Centre on AIDS, 'AIDS Surveillance in Europe-Quarterly Report', No. 21, March, Paris, 1989.

Kingdom (particularly Edinburgh <sup>52</sup>), United States, and many of the countries in Europe have observed increases in HIV infection among IV drug users over short periods. <sup>53</sup>

Figure 2 (top and bottom graphs) shows in graph form the increase rate of transmission of AIDS by the known high-risk practices in Australia as at July 1993. <sup>54</sup>



<sup>52</sup> In fact, many studies have focused on Edinburgh because historically the city has had the most noticeable drug problem. See for more detail studies by, Follett, E.A., McIntyre, A., O'Donnell, B., *et al* 'HTLV-III Antibody in Drug Abusers in the West of Scotland: the Edinburgh Connection', *Lancet*, 1986, 2:446-447; and Robertson, R., 'The Edinburgh epidemic - a case study', in Strang, and Stimson, *supra* note 41, 95-107.

<sup>53</sup> Centre for Disease Control (US), 'Prevalence and Rate of Spread of HIV in the United States', *AIDS/HIV Rec*, November, 1988, 10-11 in which it was stated that the proportion of reported cases with a history of IV drug usage in the United States had increased from 24% in September 1986-August 1987 to 29% in September 1987-August 1988. Losos, J., Wells, G., Elmslie, K., *et al*, 'Acquired Immune Deficiency Syndrome in Canada: the First 5 years of Surveillance', *Can Med Assoc J*, 1988, 139:383-388. For Europe, IV International Conference on AIDS, Stockholm, 12-16 June 1988, *Abstract Volumes and V International Conference on AIDS*, Montreal 4-9 June 1989, Abstract Volumes, 117.

<sup>54</sup> from Kaldor, J., McDonald, A. M., Blumer, C. E., *et al*, 'The acquired immunodeficiency syndrome in Australia: incidence 1982-1991' *Med J Aust*, 1993, 158:10-17, Figures 1-2, p 12.



Looking at the top graph above, the curve applying to homosexual/bisexual transmission and blood transfusion related transmission has stabilised markedly since mid-1989. By contrast, in the bottom graph the cases attributed to the combination of male homo/bisexual contact/IV drug use and other IV drug use have risen steadily from mid-1987. This trend has continued into 1993.<sup>55</sup> The link between heterosexual cases and IV drug use is certainly supported by research that has been conducted in other countries. For example, in the United States at one STD clinic, 66% of AIDS cases attributed to heterosexual contact involved persons who reported contact with a person with increased risk for HIV infection because they were IV drug users, bisexuals or recipients of infected blood products.<sup>56</sup> Increases in syphilis among heterosexuals, particularly among prostitutes, drug users and their sexual contacts, as shown in the United States would also tend to support this.<sup>57</sup> In 1992 in Australia, of the 15,679 cases of HIV infection (which are cases not fulfilling the 'case definition' of AIDS), 3.2% of that total were infected through IV drug use/heterosexual contact and 1.6% of the total through male homosexual/IV drug use.<sup>58</sup> Figures quantifying heterosexual transmission may not be accurate since an individual may be categorised in another manner, for example, as an IV drug user, homosexual or bisexual. Despite this, in 1991, Carr stated that in Australia the 'second wave' of cases that was predicted within the IV drug user/heterosexual group had not developed to the extent feared.<sup>59</sup>

In 1991, Carr also stated that there was no evidence to suggest that the course of the Australian HIV/AIDS epidemic would follow the course of the United States statistics. He does acknowledge however that the statistics presented may not be complete and that it is the statistics for antibody testing rather than the number of cases fulfilling the criteria of case definition of AIDS which need to be focused on. Even then, such figures are

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<sup>55</sup> *Australian HIV Surveillance Report*, 1994, 10/2: 9, Table 1.2.

<sup>56</sup> Centre for Disease Control (US), 'Update: Heterosexual Transmission of Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection - United States', *MMWR*, 1989, 38:423-434. The study by the Public Health Laboratory Service Working Group in England entitled, 'Prevalence of HIV antibody in high and low risk groups in England', *BMJ*, 1989, 298:422-423, found that heterosexual spread of HIV in England is still largely confined to subjects whose partner has an identifiable risk such as IV drug use.

<sup>57</sup> Centre for Disease Control, 'Relationship of syphilis to drug use and prostitution - Connecticut and Philadelphia, Pennsylvania', *MMWR*, 1988, 37:755-780, at p. 764.

<sup>58</sup> *Australian HIV Surveillance Report*, 1992, 8(suppl 1):84, Table 3.2.

<sup>59</sup> Carr, A., 'The HIV Epidemic: the next ten years' (1991) *National AIDS Bulletin*, October, 7-11, Table 10, at p. 10.

not fully indicative of the total cases as most are obtained as the result of voluntary testing. In fact, in a 1991 Victorian study, 82% of tests conducted were of persons for which no HIV exposure category was reported.<sup>60</sup> This would lend weight to the theory that at risk persons may not be coming forward for testing in Victoria. There is no reason to suggest that other States might not be experiencing a similar pattern. For example, in Tasmania one might expect fewer people to present for testing given that homosexual conduct is still illegal in that State.<sup>61</sup> As a result of these findings, it is reasonable to assume that relatively sizeable increases in infection in some exposure categories can pass undetected for some time. As such, a further spread of infection among IV drug users was regarded by Wodak in 1991 as both 'inevitable and imminent'.<sup>62</sup>

However, by December 31 1993, the 'second wave' has still not appeared. Table 2<sup>63</sup> presented below is most useful to illustrate this point.

DESCRIPTION	1985 <sup>1</sup>	1986	1987	1988	1989	1990	1991	1992	1993
<b>Total Cases</b>	3941	2629	2772	1712	1609	1405	1414	1206	998
<b>Males (%)<sup>2</sup></b>	96.1	95.7	96.1	94.7	94.7	92.6	94.4	92.0	92.1
<b>Mean Age:</b>									
Males	31	31	32	33	33	32	33	34	34
Females	29	32	32	31	28	30	31	33	29
<b>State/Territory (%):</b>									
ACT	0.7	1.3	0.8	0.7	0.7	1.1	0.6	1.0	0.7
NSW	70.6	72.7	75.1	68.1	59.1	56.0	57.8	56.4	51.0
NT	0.2	0.2	0.5	0.2	0.4	0.6	0.4	0.5	0.9
QLD	4.4	5.8	5.0	7.1	10.2	10.5	11.1	13.1	14.3
SA	2.3	2.1	2.4	2.9	4.6	4.6	3.2	2.8	5.5
TAS	0.1	0.1	0.2	0.1	0.8	0.6	0.4	0.8	0.4
VIC	18.5	13.5	12.8	16.9	20.3	21.7	21.8	21.2	22.9
WA	3.2	4.3	3.2	4.0	3.9	4.9	4.7	4.2	4.3
<b>Exposure Category (%)<sup>3</sup>:</b>									
Male homosexual/bisexual contact	83.5	84.0	86.0	83.3	80.7	79.3	78.8	74.4	76.6
Male homosexual/bisexual contact and ID use	2.1	2.7	3.2	2.0	3.1	3.0	2.6	3.5	3.4
ID use (female and heterosexual male)	2.5	5.0	4.9	7.4	6.7	6.5	5.5	5.6	4.7
Heterosexual contact	1.3	2.0	3.0	5.1	7.2	9.5	11.2	14.6	14.4
Haemophilia/coagulation disorder	7.8	4.2	1.5	0.6	0.3	0.1	0.3	0.2	0.0
Receipt of blood transfusion, blood components, or tissue	2.6	2.0	1.3	1.5	1.6	1.4	1.2	1.4	0.7
Mother with/at risk for HIV infection	0.2	0.1	0.1	0.1	0.4	0.2	0.4	0.3	0.2
Other/undetermined	54.3	50.6	40.5	24.2	26.2	30.7	28.4	16.2	14.9

1. Diagnoses in 1985 or earlier.

2. Proportion of males among cases whose sex was reported.

3. The 'Other/undetermined' category was excluded from the calculation of the percentage of cases attributed to each exposure category.

<sup>60</sup> Gertig, D., Crofts, N., Stevenson, E., *et al*, 'The epidemiology of HIV-1 infection in Victoria', *Med J Aust*, 1993, 158/1: 17-20.

<sup>61</sup> Under section 122-123 of the *Criminal Code* (1924)(Tas.).

<sup>62</sup> Wodak, A., 'To Take up Arms Against a Sea of Drugs: AIDS Infecting Drug Users and Drug Policy', *HIV Infection and AIDS*, Sydney, *Proceedings of the 1991 Annual General meeting of the Australian Academy of Science*, 1991, 61- 70, at pp. 64-65.

<sup>63</sup> Reproduction of Table 1.1 *Australian HIV Surveillance Report*, 1994, 10/2:8.

Table 2 illustrates that of the total 17,737 cases of HIV infection (from 1985-December 1993) only 4.7% of the newly diagnosed infections for 1993 were transmitted by IV drug use/heterosexual contact and 3.4% of the total were transmitted through male homosexual/IV drug use.

Two important facts can be gleaned from the table. First, it is significant to note that if one follows through the exposure category for 'male homosexual/bisexual contact and drug use' it can be seen that the rate increased moderately between 1991-1992 (a rise from 2.6% to 3.5% of the total cases) but decreased marginally between 1992-1993 (from 3.5% to 3.4%). In the 'IV drug use' exposure category the number of cases remained almost constant between 1991-1992, between 5.5-5.6% of the total but decreased between 1992 and 1993 (from 5.6% to 4.7%). It is significant to note that the peak period for male homosexual IV drug use was in 1992 when the rate was 3.5%. By contrast, the peak period for heterosexual/IV drug use category was in 1987 and 1988 when the figures were 7.4% and 6.7% respectively. The rate has decreased steadily since then.

Second, it is clear that in 1991 at the time of Carr's predictions there was a large undetermined category (29.2% of the total) which has dropped to 14.9% in 1993. While the drop has brought some reliability to the 1993 figures, the 1991 rate does bring into question Carr's predictions at that time. The safest conclusion that can be drawn as at June 1993 is that the increase attributed to IV drug use has levelled off but it is still unclear as to what has prompted this and to what extent these figures are reliable at all. There could be a direct link between containment of these figures and the establishment of needle-exchanges in Australia. However, it is difficult to assess in the absence of conclusive research on the point and the reliability of such information would be questionable given the short life-span of these exchanges. One could posit though that drug users do not appear to pose a significant risk to the criminal justice system or a drain on public health resources in Australia.

There has been very little increase in AIDS cases in the adolescent/young adult age category in Australia. For example, in July 1988, 6 out of 943 or 0.6% of Australian AIDS cases were recorded in the 10-19 year age category.<sup>64</sup> By December 31 1993 (5 years later) the case number had

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<sup>64</sup> *Communicable Diseases Intelligence Bulletin*, 1988, 17:3. The 10-19 year age group was re-categorised in 1990 as 13-19 years.

increased to 19 out of 4753 but represented only 0.4% of the total number of cases.<sup>65</sup> By contrast, the death rate from AIDS has been very high in that group with 13 of the 19 or 73% of the total adolescents having died since they have acquired the disease.

Figures that indicate a low rate of increase among adolescents should be viewed with caution since Australian and American studies have established that teenagers still believe they are immune from HIV infection.<sup>66</sup> A 1992 Queensland survey of 175 class groups from 72 randomly selected high schools (students in years 10, 11 and 12) examined students' attitudes to sex and antibody testing. The survey found that only 28% of girls and 53% of boys always used a condom during intercourse even though they had received education in safe-sex practices. In addition, one of the main reasons cited by the students for not using a condom was that the female partner was on the contraceptive pill, indicating that preventing pregnancy was more of a concern rather than preventing disease transmission.<sup>67</sup>

### 3. THE MEDICAL ASPECTS OF AIDS

AIDS was first recognised in 1981<sup>68</sup> after increasing numbers of homosexuals developed hitherto unknown clinical manifestations, 'opportunistic' infections (for example, PCP a form of pneumonia which until then had been rare) and/or a form of skin cancer known as 'kaposi's sarcoma'. These men and later, other non-homosexual AIDS persons, were found to have profound defects

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<sup>65</sup> *Australian HIV Surveillance Report*, 1994, 10/2: 11, Table 2.3.

<sup>66</sup> In Australia, Stollznow Research Pty. Ltd., *Pilot Investigation into the Attitudes Adopted by doctors Towards AIDS and a Study of 17-25 Year Old Attitudes Towards AIDS*, Sydney, Stollznow Research Pty. Ltd., 1988. In the United States, Strunin, L., and Hingson, S. D., 'Acquired Immunodeficiency Syndrome and Adolescents: Knowledge, Beliefs, Attitudes and Behaviours', *Paediatrics*, 79(5): 825-828. In the more recent American study of Zimet, G. D., Diclemente, R. J., Lazelanik, *et al*, ('Changes in Adolescents Knowledge and Attitudes About AIDS over the Course of the AIDS Epidemic', *J Adolesc H*, 1993, 14(2):85-90) it was concluded that efforts must be increased to educate younger school students. This study found that younger students had a lower AIDS knowledge score in 1991 than their similarly aged counterparts did in 1989.

<sup>67</sup> Study by Dunne, M. P., Donald, M., Lucke, J., and Raphael, B., from National Centre for HIV Social Research, University of Queensland, National Centre for HIV Epidemiology and Clinical Research, *Australian HIV Surveillance Report*, 1992, 8/4: 1, 3.

<sup>68</sup> The initial cases were reported to CDC who published an account of them in 'Pneumocystis Pneumonia - Los Angeles' *MMWR*, 1981, 30: 250-252; 'Kaposi's sarcoma and pneumocystis pneumonia among homosexual men - New York City and California', *MMWR* 1981 30: 305-308.

in their immune systems. Since these defects had become apparent during adulthood, they were considered to be acquired rather than congenital (at birth). By 1983, the Centre for Disease Control (CDC) in the United States, had formally named this syndrome AIDS, and defined it as a disease or the end stage of infection with a virus known as Human Immunodeficiency Virus (HIV).<sup>69</sup> To understand the devastating effect of HIV it is necessary to examine what is meant by immunity and how the immune system functions.

## IMMUNITY

Human beings are exposed to a number of infectious agents. Most of these organisms are killed before they cause serious harm. Immunity can be classified into four groups: Innate Immunity, Acquired Immunity, Cell Mediated Immunity and Immunisation.<sup>70</sup> Innate Immunity is made up of four components which act as barriers; the skin, the gastric juices and enzymes that line the gastrointestinal tract, proteins in the bloodstream that neutralise bacteria, and cellular components, such as white blood cells and macrophages. The process of acquired immunity begins at birth and is characterised by a maturation of lymphocyte cells. Lymphocytes pass into the bloodstream and enter the lymph nodes where they reside until an infectious agent enters the body. They then act

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<sup>69</sup> Mann, *supra* note 28, at p. 35. The virus however, was not named the Human Immunodeficiency Virus (HIV) until 1986. The name was recommended by the International Committee on the Taxonomy of Viruses (Coffin, J., *et al*, 'What to call the AIDS virus?' *Nature*, 1986, 321:10). The virus was claimed to have been discovered by Montagnier and his colleagues at the Institut Pasteur in Paris and Gallo of the National Cancer Institute in the United States.

An article appearing in *Cancer Research* by Duesberg in March 1987 challenged the view that AIDS was caused by HIV (Duesberg, P. H., 'Retroviruses as carcinogens and pathogens: expectations and reality', *Cancer Res* 1987, 47:1199-1220). This led to a number of comments being made by researchers in academic journals (see the arguments in favour of HIV as the virus causing AIDS by Blattner, W., Gallo, R. C., and Temin, H. M., in 'HIV Causes AIDS', *Science*, 1988, 241:514 and 517, and the arguments against HIV causing AIDS by Duesberg, P.H., 'Duesberg's Response to Blattner and Colleagues', *Science*, 1988, 241:515-516). The matter was expounded upon by Jad Adams in a book entitled *AIDS: The HIV Myth*, London, Macmillan, 1989, which pointed to the commercial interests tied to the HIV view and criticised the medical establishment for silencing or ridiculing Duesberg. Adams has not been immune from criticism for his support of Duesberg and alternative theories. See 'AIDS and HIV: A myth?' *Lancet*, 1989, 2:1031 and Stewart, G. T., 'Uncertainties about AIDS and HIV', *Lancet*, 1989, 2:1325. The debate that HIV is an effect rather than a cause resurfaced again in 1992-1993: Schechter, M T., Craib J. P., Gelmon, K. A., 'HIV 1 and aetiology of AIDS' *Lancet*, 1993, 341: 658-659. In light of the academic misgivings the best that can be said is that HIV is *generally* thought by a majority of the medical fraternity, to be the cause of AIDS rather than any other etiologic factor. To what extent this decision serves the interests of any particular group, company, organisation or any individual in society will not be discussed in this thesis.

<sup>70</sup> Kimball, J. W., *Introduction to Immunology*, 2nd ed, New York, Macmillan, 1986, chapter 1.

to neutralise that agent.<sup>71</sup> Where antibodies remain in the bloodstream for years protecting the individual from re-infection with the same organism, an individual possesses what is known as acquired immunity.

The process known as cell mediated immunity is characterised by the thymus gland producing a sub-population of lymphocytes called T-lymphocytes which enter the bloodstream, attacking the offending infectious substance, and, along with antibodies, help destroy it. T-lymphocytes have two sub-groups, T-helper and T-suppressor cells. The helper cells enhance immune responsiveness in fighting infection and the T-suppressor cells inhibit the immune reaction after the infectious process has been cleared.<sup>72</sup>

Finally, the best known method of developing immunity to modern diseases such as chicken pox, poliomyelitis, tetanus and the flu, is through immunisation. This is the process whereby vaccines against the virus are injected into the body of an individual in order to provide an immunity from that disease.<sup>73</sup>

#### HUMAN IMMUNODEFICIENCY VIRUS (HIV)

An individual may possess or acquire a deficiency in his or her immune system either at birth (congenital) or during his or her lifetime (acquired). AIDS is an example of the latter. Individuals with AIDS characteristically have T-lymphocytes that are damaged by HIV. This increases their susceptibility to 'opportunistic' infections. The virus itself contains ribonucleic acid (RNA) together with an enzyme called reverse transcriptase. HIV is a retrovirus which by definition means that reverse transcriptase allows the 'virus' RNA to be transformed or translated back into deoxyribonucleic acid (DNA), reversing the usual sequence from DNA to RNA.<sup>74</sup>

Moreover, prior to 1985, it was thought that there was only one HIV virus. In that year data from West Africa revealed a new isolate; one that was not

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<sup>71</sup> Kimball, *Ibid*, at pp. 3-5

<sup>72</sup> Said, J., 'Pathogenesis of HIV Infection', in Nash, G., and Said, J. (eds), *Pathology of AIDS and HIV Infection*, Philadelphia, W.B. Saunders Co, 1992, 15-18 at p. 17.

<sup>73</sup> Kimball, *supra* note 64, at p. 3-5.

<sup>74</sup> Mann, *supra* note 28, at p. 36. For a more detailed description of the biology of HIV, see: Weber, J., 'AIDS: The Virus, Antivirals and Vaccines', *Br J Hosp Med*, February 1987, 135-141; Gallo, R. C., and Montagnier, L., in 'AIDS in 1988', *Sci Am*, 1988, 259(4):25-32.

simply a strain of the original HIV but a new virus designated HIV-2. Both HIV-1 and HIV-2 are similar in structure yet HIV-2 is epidemic mainly in West Africa.<sup>75</sup> In October 1988, Gallo and Montagnier stated that the pathogenic potential of HIV-2 was not as clearly established as HIV-1.<sup>76</sup> Since the RNA sequences of HIV compare with that of the retrovirus from African Green Monkeys it is thought that HIV-2 may have mutated from this simian immunodeficiency virus (SIV) but not so for HIV-1.<sup>77</sup> However, in 1989 scientists from the Centre Internationale de la Recherche Medicale de Franceville in Gabon, West Africa reported finding two wild chimpanzees that were seropositive for HIV. The virus was found to be like HIV-1 and may provide evidence that the chimpanzees could have been the source of the human infection.<sup>78</sup> The fact that there is such a wide variation of RNA sequences, leads to the concern that, as with influenza, a single source of vaccine may not be sufficient to immunise against all such variants.<sup>79</sup>

The virus can infect those cells that have particular receptor sites on their outer surface, such as T-helper lymphocytes (T4 cells), cells that express the CD4 antigen.<sup>80</sup> As the cell is penetrated, the reverse transcriptase works on the RNA making DNA copies and that DNA then moves into the nucleus of the host cell integrating itself into the genetic material of the host cell. HIV enters its target cells by interacting (or binding) with the molecule called CD4.<sup>81</sup> The virus

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<sup>75</sup> Clavel, F., 'HIV-2 - the West African AIDS virus', *AIDS*, 1987, 1:135-140. This position is still regarded as correct.

<sup>76</sup> Gallo and Montagnier, *supra* note 68, at p. 29. However, as HIV-1 and HIV-2 are identified by the same tests and give rise to generally the same symptoms, in this thesis the term 'HIV' will be used in a general sense.

<sup>77</sup> Albion Street AIDS Centre, *The AIDS Manual*, Sydney, The Albion Street Centre, 1989, at p. 9. See also, Gardner, M., Marx, P., 'Simian AIDS', in *Advances in Viral Oncology*, Vol. 5, New York, Raven Press, 1985, 57-81. Kanki, P. J., and Essex, M., 'Origins of HTLV-III (HIV)', in Wormser, G. P., Stahl, R. E., and Bottone, E. J., (eds), *AIDS - and Other Manifestations of HIV Infection*, New Jersey, Noyes Publications, 1987, at pp. 250-256.

<sup>78</sup> Short, R., 'HIV Infection and AIDS - The Global Scene', in *HIV Infection and AIDS*, Sydney, Proceedings of the 1991 Annual General meeting of the Australian Academy of Science, 1991, 15-29, at p. 26.

<sup>79</sup> Marx, J., 'The AIDS Virus Can Take On Many Guises', *Science*, 1988, 241:1039-1040.

<sup>80</sup> The virus has also been found to infect cells lacking CD4 such B lymphocytes, promyelocytes, fibroblasts and epidermal Langerhan's cells (Levy, J. A., 'Features of HIV and the Host Response that Influence Progression to Disease', in Sande, M.A., and Volberding, P. A., (eds), 3rd ed, *Viral and Immunologic Factors in HIV infection*, Philadelphia, W.B. Saunders, 1992, 18-22, at p. 19.

<sup>81</sup> Fauci, A., *et al*, 'Immunopathogenic Mechanisms in HIV' *Ann Intern Med*, 1991, 114:78.

also infects macrophages which Gallo and Montagnier believe bring the virus into the brain. This explains the neurological conditions associated with HIV-infection.

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The virus lies dormant, but, when activated, it produces new viruses which burst out of the cell, fusing with and killing healthy cells and infecting others in order to continue the process. It is believed that the virus may become active upon activation of the immune system.<sup>83</sup> It is only upon cell activation in this manner, that an individual will develop the clinical symptoms of AIDS. Prior to this time, an individual may be infected with HIV but the virus lies dormant in his or her body without developing into AIDS.<sup>84</sup> The individual may at this stage be an asymptomatic (symptomless) carrier of the virus. Factors that may be responsible for activating HIV to progress to AIDS are discussed in a later section of this chapter.

### MODES OF TRANSMISSION OF HIV

The main body fluids through which transmission occurs are blood and semen. The HIV virus has also been isolated in human tears, saliva<sup>85</sup>,

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<sup>82</sup> Gallo and Montagnier, *supra* note 68, at p. 29.

<sup>83</sup> Kay, K. (ed), *AIDS Virus Infection*, Sydney, The Albion Street Centre, 1986, para. 2.1-3.8. Mann, *supra* note 28, at p. 47, Marx, *supra* note 73, at pp. 1039-1040 and Weber, *supra* note 68, at p.136-137.

<sup>84</sup> It is because of this capacity that AIDS is labelled a 'lentivirus' (slow virus) (Levy, *supra* note 74, at p. 18). Weber, in fact suggests that it is not correct to suggest that the virus is latent as a whole in the body. He believes that there is a continuous low level replication of HIV throughout the course of the infection (*supra* note 68, at p. 138).

<sup>85</sup> Saliva is said to contain one-tenth to one-hundredth of the amount of virus in the blood and plasma and at less frequency (Levy, *supra* note 74, at p. 21). Although it is thought that the virus cannot be spread by casual social contact, for example, where saliva is exchanged, *Lancet* did report one known case where it was likely that the virus was transmitted during a fight between two sisters. The infected sister bit the other while her mouth was bleeding and infected the other (Anon., 'Transmission of HIV by human bite', *Lancet*, 1987, 1:522). It is more likely that this was in reality an instance of blood to blood transmission. As Lifson, A. states, in 'Do Alternative Modes for Transmission of Human Immunodeficiency Virus Exist?', *JAMA*, 1988, 259(9):1353-1356, 'If HIV were readily transmitted through contact with saliva, it would be most evident in one of three settings: during traumatic exposures (such as bites), after parenteral or mucous membrane exposures in the health care setting, or during sexual contact (oral-oral or oral-genital)'. Correspondence in *Lancet* (Rozenbaum, W., Ghrakhanian, S., Cardon, B., *et al*, 'HIV Transmission by oral sex' 2:1395; Dassey, D. E., Delels, R., Visscher, B, *et al*, 'HIV and orogenital transmission' 1988, 2:1023-1024; Goldberg, D. J., Green, S. T., Kennedy, D. H., *et al*, 'HIV and orogenital transmission' 1988, 2:1248; Levy, J., Greenspan, D., 'HIV in saliva' 1988, 2:1363) debate whether HIV can be transmitted through orogenital contact. A 1989 study has suggested that microlesions in the mouth cavity following vigorous kissing or teeth brushing may result in blood in the saliva which may be highly infectious in HIV infected persons (Piazza, M.,



breast milk <sup>86</sup>, and cerebrospinal fluid. <sup>87</sup> Although the possibility of transmission by saliva has been considered, there has not been a conclusive documented case of HIV being transmitted through this source alone. This renders the risk of infection by biting or spitting exceedingly low. <sup>88</sup> HIV has been conclusively found to be transmitted in four ways. These are through the exchange of bodily fluids during intimate sexual contact; <sup>89</sup> when infected blood or blood products are used; when contaminated needles are shared amongst intravenous (IV) drug

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Chirianni, A., Picciotto, L., *et al*, 'Passionate Kissing and Microlesions of the Oral Mucosa: Possible Role in AIDS Transmission', *JAMA*, 1989, 261:244-245). With respect to oral sex, one report lists seroconversion in two homosexual men who did engage in rectal intercourse for at least 5 years but had engaged in oral sex with ejaculation (Lifson, A.R., O'Malley, P.M., Hessel N.A.S., *et al* ' HIV seroconversion in two homosexual men after receptive oral intercourse with ejaculation: Implications for counselling concerning safe sexual practices', *Am J Pub Health*, 1990, 80:1509). By contrast in another study, no seroconversions occurred in 147 gay men who practiced only oral sex (Kingsley, L. A., *et al* 'Risk factors for seroconversion to human immunodeficiency virus among homosexuals', *Lancet*, 1987, 1:345-348). In 1991 there was another report of HIV being transmitted to a male who engaged in oral sex only and who had not had penetrative sex for 8 years or ever injected IV drugs (Murray, A. B., *et al* 'Coincident acquisition of Neisseria gonorrhoea HIV from fellatio' [letter] *Lancet*, 1991, 338:830). In the absence of any definitive statement, guidelines have been formulated worldwide to reduce exposures to the saliva of infected persons in for example, health care, school settings and in police departments.

<sup>86</sup> Lifson, *ibid* states that HIV has been isolated in breast milk and he cites the report from Australia of Ziegler, J.B. *et al*, 'Post-Natal Transmission of AIDS-Associated Retrovirus from a Mother to an Infant', *Lancet*, 1985, 1:896-897, where HIV was transmitted to an infant from its mother who had received a HIV contaminated blood transfusion during labour. By 1992 breast feeding was thought to account for a substantial proportion of mother-to-child transmissions or at least substantially increase the risk of transmission of HIV during the perinatal period (European Collaborative Study, 'Risk Factors for Mother-to-Child Transmission of HIV-1', *Lancet*, 1992, 339:1007-1012).

<sup>87</sup> Studies reveal that while there is a high level of the virus in this fluid, it is not a natural source of infection (Levy, J. A., Hollander, H., Shimabukuro, J., *et al* 'Isolation of AIDS-associated retroviruses from cerebrospinal fluid and brain of patients with neurological symptoms', *Lancet*, 1985, 1:586).

<sup>88</sup> See studies in footnote 79.

<sup>89</sup> Marx, J. L., in 'Do Sperm Spread the AIDS Virus?' *Science*, 1989, 245:30 reports that conflicting results of studies conducted during 1989 reveal that scientists are not willing to rule out the possibility that sperm actually carry the AIDS virus because of the concentration of blood in the sperm. Following this, Levy, *supra* note 74 states that genital secretions including sperm and vaginal and cervical fluids vary in virus quantity but generally have much less than the blood (at p. 21).

users; and by mother to child either, peri- (before birth) or neo-natally (after birth).<sup>90</sup> Each of these will be described briefly below.

#### (i) Sexual Transmission

It is now clear that HIV may be spread not only by homosexual conduct but also by heterosexual sexual activity. As to genital secretions, Levy has stated that 'up to 5% of white cells in seminal fluid, can be HIV infected'.<sup>91</sup> He believes that the numbers of infected cells in the ejaculate relates directly to the ability to transfer the virus to others. It might also explain why several partners of some seropositive individuals do not get infected: the genital fluids do not contain a large enough number of infected cells at a particular time.

The Center for Disease Control (US) has stated that a person's risk of acquiring HIV through sexual contact is dependent upon a number of factors. These include: the number of infected sexual partners a person has with whom safe sexual practices are not adopted, whether if infected, the partner has STD infections, the type of sex practice engaged in (anal intercourse is a higher risk practice than vaginal (non-traumatic) sexual intercourse), the varying level of infectivity of the partner (i.e the number of infected cells) due to the stage of the disease in a partner,<sup>92</sup> and, whether the infected partner is homosexual, bisexual, a prostitute or IV drug user and does not adopt safe sexual practices.<sup>93</sup> The presence of any or all these factors increases the risk of transmission.<sup>94</sup>

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<sup>90</sup> Windom, R., *AIDS and the Public Health Service*, U.S. Department of Health and Human Services, Atlanta, Centers for Disease Control, 1987. These observations of the modes of transmission and the risk-groups have remained virtually unchanged since 1982.

<sup>91</sup> Levy, *supra* note 74, at pp. 21-22. This is supported by Padian, N. S., Shiboski, S., and Jewell, N. P., ('Female to Male Transmission of Human Immunodeficiency Virus, *JAMA*, 1991, 266:1664).

<sup>92</sup> Where the CD4+ cell count is fewer than 200/Ml/e, sex partners are more likely to become infected (Goedert, J.J., Eyseter, M.E., Biggar, R.J., *et al*, 'Heterosexual transmission of human immunodeficiency virus, Association with severe depletion of T-helper lymphocyte in men with haemophilia', *AIDS Rev. Hum Retrov*, 1988, 3:355-361). See also study where transmission common in partners with less advanced disease: De Vincenzi, I., Ancelle-Park, R., 'Heterosexual transmission of HIV: Follow-up of a European cohort of couples'. *Abstracts of the Seventh International Conference on AIDS*, Abstract MC 3028, Florence 1991.

<sup>93</sup> Centre for Disease Control, 'Update: Heterosexual Transmission of Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection - United States' *MMWR*, 1989, 38:423-434. Safe sexual practices involve the use of condoms, ascertaining the risk category and antibody status of sexual partners and limiting the number of sexual contacts.

<sup>94</sup> *Ibid*, 423-434.

With homosexuality, it is anal intercourse and other practices resulting in rectal trauma, such as fisting which increase the risk of infection. In heterosexual terms for women also anal intercourse carries more risk of transmission than vaginal intercourse.<sup>95</sup> One study found that a person was 2.5 times more likely to become infected with HIV as a result of anal rather than vaginal intercourse with an infected partner.<sup>96</sup> Anal sex is frequently practiced by heterosexuals in Africa as means of contraception, and this combined with the high incidence of prior STD infection accounts for the high incidence of HIV infection among heterosexuals in Africa.<sup>97</sup>

In fact, the presence of other ulcerating sexually-transmitted diseases in an individual is believed to be a co-factor in HIV transmission.<sup>98</sup> Genital ulcers are also a component which might explain why the disease spread so quickly in Africa where genito-ulcerative disease is more common. Thus the probability that any single episode of genital-genital intercourse will result in transmission of HIV will be increased when these factors are present.<sup>99</sup> The link between HSV (Herpes) and HIV has been found even after controlling for lifestyle and behaviour.<sup>100</sup> If this is true, then strengthening of programmes to control sexually-transmitted diseases is timely for public health departments.<sup>101</sup>

<sup>95</sup> Padian Shiboski and Jewell, *supra* note 85.

<sup>96</sup> Lazzarin, A., Sarocco, A., *et al* 'Man to Woman Sexual Transmission of the Human Immunodeficiency Virus: Risk Factors Related to Sexual Behaviour, Man's Infectiveness, and Woman's susceptibility' *Arch Intern Med* 1991, 151:411.

<sup>97</sup> Quinn, T. C., 'AIDS in Africa; Evidence for Heterosexual Transmission of the Human Immunodeficiency Virus', *NY State J Med*, May 1987, 286-289.

<sup>98</sup> Piot, P., and Laga, M., 'Genital Ulcers, Other Sexually Transmitted Diseases, and the Sexual Transmission of HIV', *BMJ* 1989, 298:623-624. This view is supported by studies that have taken place in Central Africa including Greenblatt, R. U., Lukehart, S. L., Plummer, F. A., *et al* 'Genital ulceration as a risk factor for human immunodeficiency virus infection', *AIDS*, 1988, 2:47-50. Cameron, D.W., Simonsen, J.N., D'Costa, L.J., *et al*: 'Female to male transmission of human immunodeficiency virus type 1, Risk factors for seroconversion in men', *Lancet* 1989, 2:403.

<sup>99</sup> Peterman, T.A, Curran, J. W., 'Sexual transmission of human immunodeficiency virus,' *JAMA*, 1986, 256:2222-2226.

<sup>100</sup> Piot, P. Plummer F.S., Mhaul, J.L. *et al* 'AIDS: an International perspective', *Science*, 1988, 239:573-577.

<sup>101</sup> WHO in a consensus statement released in February 1989 suggested that genital ulcer disease intervention may help to prevent sexual transmission of HIV. WHO, 'Consensus Statements on HIV Transmission', *Lancet*, 1989, 31:96.

As to risk analysis, Hearst and Hulley examined results from a number of studies conducted in the United States between 1986-1988 in which a variety of methodologies were used. After analysing the results of these studies they concluded that the risk in one heterosexual encounter (without a condom) with a person infected with HIV, to be about one in 500 while the risk for one heterosexual encounter (without a condom) with someone whose HIV status is unknown and is thought not be in any high-risk group to be one in 5 million.<sup>102</sup> The risk of seroconversion (risk of contraction of the disease) has been placed at one in 1,000 for unprotected sexual intercourse (without a condom) with a person in a high-risk group. Hearst and Hulley also believed that the risk of contracting HIV in a single sexual encounter with a member of high-risk group while using a condom is one in 10,000.<sup>103</sup> When considering these figures it must be noted that the methodology used in many studies was to interview persons (some of whom were self-referred and others obtained from clinics and hospitals) about their sexual history and that of their partner, and about their membership of a high-risk group. It is therefore possible that an individual might have provided inaccurate information with respect to these circumstances.

Further studies in the US have found that there are variable rates of heterosexual transmission among sex partners of HIV-infected individuals. In 1992 the European Study Group on Heterosexual Transmission of HIV concluded in a study of 563 stable couples (relationship of median time of 3 years with sexual contact three times per week) that the transmission of HIV from male to females was around twice as efficient as from female to male.<sup>104</sup> In the same year in the US, it was found that women accounted for the most persons infected through heterosexual contact.<sup>105</sup> Some statistics are available for the rates of infection across certain risk-groups. For example, the rates of infection range from 9-20% for female sexual partners of infected male haemophiliacs;<sup>106</sup>

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<sup>102</sup> Hearst, N., Hulley, S. B., 'Preventing the heterosexual spread of AIDS. Are we giving our patients the best advice?' *JAMA* 1988, 259:2428-2432.

<sup>103</sup> *Ibid*, at p. 2430.

<sup>104</sup> European Study Group on Heterosexual Transmission of HIV 'Comparison of Female to Male and Male to Female Transmission of HIV in 563 Stable Couples' *BMJ* 1992,304: 809. This confirmed the earlier study of Padian, N., Marquis, L., Francis, D. P. *et al*, 'Male to Female Transmission of Human Immunodeficiency Virus', *JAMA* 1987, 258:788

<sup>105</sup> *MMWR*, *supra* note 22, at p. 551. Women in fact accounted for 59.4% of cases.

<sup>106</sup> Mann, J.M., Quinn, T.C., Francis, H., *et al* 'Prevalence of HTLV-III/LAV in household contacts of patients with confirmed AIDS and controls in Kinshasa, Zaire', *JAMA*, 1986, 256: 721-724.

26% for female sexual partners of bisexual men; <sup>107</sup> 19.7% and 14.8% respectively for female and male sexual contacts of transfusion recipients, <sup>108</sup> and 47.8% and 50% respectively for female and male sexual contacts of intravenous drug users. <sup>109</sup>

## (ii) Blood-Blood Transmission

Transmission of the virus through contaminated transfused or transplanted blood or blood products is now well-known and well documented in a number of countries. <sup>110</sup> Blood products, particularly Factor VIII, a life saving blood-clotting agent used by haemophiliacs to either stop bleeding episodes or prevent new ones, has been associated with transmission because of the way in which Factor VIII is prepared and manufactured. <sup>111</sup> However, the practice in developed countries of heating blood products to kill the virus has largely eliminated transmission of HIV through this mode. <sup>112</sup> Where blood screening

<sup>107</sup> Ryder, R. W., Hassig, S. E., 'The Epidemiology of perinatal transmission of HIV', *AIDS* 1988, 2 (suppl 1): S83-S89.

<sup>108</sup> Center for Disease Control, *supra* note 87.

<sup>109</sup> Kelen, G.D., DiGiovanni, T., Bisson, L., *et al* 'Human immunodeficiency virus infection in emergency patients: Epidemiology, clinical presentations, and risk to health care workers; The Johns Hopkins experience', *JAMA* 1989, 262:516-522.

<sup>110</sup> See in the United Kingdom, Plowden, B., 'The Importing of AIDS', *New Society*, October 23 1987, 16-17. In the United States, Roling D. A., 'Transfusion-Associated Acquired Immunodeficiency Syndrome (AIDS): Blood Bank Liability?' (1986) 16 *Baltimore Law Review*, 81-116. In Australia, *Dwan v Farquhar* [1987] Qd R 600, *H v Royal Princess Alexandra Hospital and Ors* [1990] Aust. Torts Reports 80-000 and *E v Australian Red Cross Society* (1991) 99 ALR 601 are cases where the question of liability for the transmission of AIDS through infected blood transfusions and blood products has been litigated with unsuccessful results for the plaintiff. An analysis of civil liability of blood banks and other persons for the transmission of HIV to haemophiliacs and others is beyond the scope of this thesis.

<sup>111</sup> Kay, *supra* note 77, at para. 12.1-12.2. Between January 1, 1981 and September 4, 1987, 407 cases of haemophiliac AIDS had been reported to the Communicable Diseases Intelligence (US). 257 or 63% of those persons had died by that date. The development of serologic methods to screen blood donors has minimised the risk, but, many haemophiliacs had been infected and this is why the numbers continue to increase. Stehr-Green, J. K., Holman, R. C., Jason, J. M., *et al*, 'Haemophilia AIDS in the United States, 1981 to September 1987', *Am J Pub Health*, 1988, 78(4):439-442. Many haemophiliacs are still at risk in rural areas of central Africa where blood is not screened (Fiander, A., 'HIV infection in Africa', *BMJ* 1989, 299:260). Reid, states that the position in Africa has improved between early 1988 and December 1988, so that by 1989 all African countries have at least one blood screening facility (Reid, *supra* note 21, 3-8).

<sup>112</sup> HIV can be destroyed outside the body by heat at 56 degrees celcius after a period of 20 minutes, in lyophilised preparations of protein (such as Factor VIII) after two hours at 68 degrees celcius and within minutes in lower concentrations by Hypochlorite, isopropyl alcohol, ethanol,

measures are mandatory as they are now in most developed countries, transmission through infected blood and blood products is much less likely unless administered with a syringe in a manner calculated to cause injury.

### (iii) Needle Sharing and Needlestick Injuries

In addition, infected blood is transmitted through the sharing of needles during IV drug usage. The risk of infection between IV drug users is said to be reduced if clean needles are used and sharing is avoided. This is the rationale behind the setting up of needle-exchange schemes. The risk of seroconversion in any single case of percutaneous exposure to an infected needle as would occur during IV needle sharing, is small - ranging from .03%-.09%.<sup>113</sup> However, because episodes of injections by IV drug users may be in the thousands the cumulative risk through drug use is high.

HIV has also been transmitted following needlestick injuries to health care workers. There have been 22 reported and 17 documented cases of needlestick injuries leading to HIV infection from six countries.<sup>114</sup>

In Australia HIV infection following from occupational exposures has been reported on two occasions.<sup>115</sup> However the frequency has not been

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hydrogen peroxide and certain detergents (*Infection Control Guidelines - Acquired Immune Deficiency Syndrome (AIDS) and Related Conditions*, March, 1988 ed. and 1990 ed., and Albion Street AIDS Centre, *The AIDS Manual*, *supra* note 71, at p. 10).

<sup>113</sup> Friedland, G. H., and Klein, P. S., 'Transmission of the Human Immunodeficiency Virus', *New Eng J Med* 1987, 317:1125-1130, at pp. 1127-1128. The risk has been calculated even lower (0.35% (3:860) - 0.4%) by Marcus, R. 'The Co-operative Needlestick Surveillance Group Surveillance of health care workers exposed to blood from patients infected with the human immunodeficiency virus', *New Eng J Med* 1988, 319:1118-1123.

<sup>114</sup> In 1993 it is reported that during the course of the HIV/AIDS epidemic only six persons from the United States who denied other risk factors for HIV infection had developed AIDS after exposures to HIV infected blood in a health-care or laboratory setting (CDC, 'Update: Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus Infection Among Health-Care Workers', *MMWR*, 1993, 42:329-337). This would tend to confirm at least in the US, that the risk associated from contact with infected persons in the health care setting may be very low.

A report has estimated that the magnitude of risk of seroconversion following needlestick injuries to HIV-infected blood to be 0.4% (American College of Physicians, 'Occupational Infection with Human Immunodeficiency Virus', *Ann Intern Med* 1989, 110(8): 653-656, at p. 653). This has been confirmed by the later study of Gerberding, J. L., and Schechter, S., 'Surgery and AIDS: Reducing the Risks', *JAMA* 1991, 265:1572.

<sup>115</sup> Australian InterGovernmental Committee on AIDS, 'Health care workers and the risk of HIV infection' (1989) *National AIDS Bulletin*, June, 16-18. In 1993 the results of a study of HIV transmission in health care workers that had been undertaken at Fairfield Hospital between 1985 and 1991 was reported. Of 230 occupational exposures to blood-borne pathogens, 75 of which were HIV related, none of these cases seroconverted to HIV. It was concluded that the risk of

systematically recorded and so the figures could be much higher.<sup>116</sup> Deep intramuscular penetrations are most likely to cause infections given the large volumes of blood and prolonged duration of contact. The immunologic health status of the recipient would be relevant to the success of transmission.<sup>117</sup> Infection control guidelines indicate that the risks of transmission by needlestick injuries, may be minimised if proper precautions, such as use of clean needles by IV drug users and the implementation of universal infection control procedures in health care settings is adopted.<sup>118</sup>

#### (iv) Mother to Child (Vertical) Transmission

The final mode of HIV transmission is peri- or neo-natal transmission. As noted earlier in this chapter, HIV has been isolated in breast milk. It is estimated that there is a 25-50% chance in Africa and a 16-30% in the US that an infected mother will transmit the virus to her offspring.<sup>119</sup> In 1992, in the US, the second largest increase in AIDS cases was recorded in the perinatal transmission group.<sup>120</sup> In Australia, by contrast an analysis of figures over the last 5 years has revealed that the rates still appear to be insignificant.<sup>121</sup> The transmission may occur in

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acquiring HIV through occupational exposure was very low (Bowden, F., Pollett, B., 'Occupational Exposure to the HIV and other blood-borne pathogens: a six year prospective study', *Med J Aust*, 1993, 158: 810-812).

<sup>116</sup> Looke, D. F. M., and Grove, D.I., 'Failed Prophylate Zidovudine After Needlestick Injury', *Lancet*, 1990, 335:1280. One such exposure occurred at Long Bay Jail where a prisoner allegedly injected a prison warden with a needle containing HIV-infected blood. As this incident was treated more as an intentional act than an accidental needlestick injury the incident is discussed in chapter three, footnote 114.

<sup>117</sup> Gerberding, J.L., Bryant Le Blanc, C.E., Nelson K.N., *et al* 'Risk of transmitting the human immunodeficiency virus, cytomegalovirus, and hepatitis B virus to health care providers exposed to patients with AIDS and AIDS-related conditions (ARC)', *J Infect Dis* 1987, 156:1-8.

<sup>118</sup> *Infection Control Guidelines - Acquired Immune Deficiency Syndrome (AIDS) and Related Conditions*, March 1988 ed. and June 1990 ed.

<sup>119</sup> Pizzo, E., 'Emerging concepts in the Treatment of HIV Infection in Children', *JAMA*, 1989, 262:1989.

<sup>120</sup> *MMWR*, *supra* note 22, at p. 551.

<sup>121</sup> The rates have remained effectively constant with any increase being marginal between 1991 and 1993 (*Australian HIV Surveillance Report*, 1992, 8/3:7, Table 1.3 and 1994, 10/2:12-13, Tables 2.4-2.5). This situation may be due to the higher standard of living and pre-natal care for women of lower socio-economic class in Australia by comparison to the United States. Both these factors may in turn be related to the lower population in general in Australia and also to the relatively low incidence of crack cocaine abuse among pregnant women in Australia.

utero (in the womb), during birth by exposure of the baby to infected blood and bodily fluids of the mother, or by breast-feeding.<sup>122</sup>

To summarise, it is unclear how efficiently HIV is transmitted during a single exposure. It appears to depend upon how much virus is in the particular bodily fluid. As the amounts of the virus are usually low in saliva it is less likely that HIV will be transmitted during such an exposure. As the levels have been shown to be high in blood, then effectiveness of transmission increases during blood-related activities. This uncertainty must be borne in mind when implementing laws relating to the transmission of HIV.

### PROGRESSION OF INFECTION WITH HIV TO AIDS

After a person becomes infected with HIV, the virus reproduces itself and infects other host cells. Some time elapses after exposure to HIV before the development of detectable antibody. This particular time period is often referred to as the 'window period' because during this period, although the person is infected, antibodies cannot be detected in his or her blood by any antibody test.<sup>123</sup> Studies support the view that generally the 'window period' could be between four weeks to three months.<sup>124</sup> The degree to which a person can infect another during the window period is unknown.<sup>125</sup>

About 2 to 4 weeks after infection, a person may develop the first clinical signs of infection in the form of an illness similar to influenza or mononucleosis. It may involve fever or nightsweats, sore throat, swelling of

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It has been suggested in the US that there is a link between pre-natal HIV infection and drug use particularly crack use (Bopp, J., and Gardner, D. H., 'AIDS Babies, Crack Babies: Challenges to the Law' (1991) 7/1 *Issues in Law and Medicine*, 3-51, at p. 5).

<sup>122</sup> Mann, *supra* note 28, at pp. 43-44 and study conducted by the European Collaborative Study, 'Mother-to-Child Transmission of HIV Infection' in *Lancet*, 1988, 2:1040-1042. Both peri- and neo-natal transmissions are examined in the study.

<sup>123</sup> Mann, *supra* note 28, at p. 37.

<sup>124</sup> *Communicable Diseases Intelligence Bulletin*, 1990, 9:8; Tindall, B., Imrie, A., Donovan, B., Penny, R., and Cooper, D., 'Primary HIV Infection: Clinical, Immunologic and Serologic Aspects' in Sande and Volberding, *supra* note 72, 68-84, at p. 74; Weber, 'HIV, the virus and laboratory tests', in Strang and Stimson, *supra* note 40 p. 35. But see, Horsburgh, C. R., Ou, C. Y., Jason, J., *et al* 'Duration of Human Immunodeficiency Virus Infection Before Detection of Antibody,' *Lancet*, 1989, 2:637 where it is stated that the 'window period' is between two months to four months and that 95% of persons register antibody positive within 5.8 months of exposure to HIV.

<sup>125</sup> Imogawa, D. T., 'HIV-1 Infection in Homosexual Men Who Remain Seronegative for Prolonged Periods', *New Eng J Med*, 1989, 320:1458.



lymph glands, muscle ache, diarrhoea and vomiting. This condition may appear following infection but before developing antibody.<sup>126</sup> This general state of malaise may disappear, only to manifest itself in several other ways, such as, persistent generalised lymphadenopathy (swollen lymph glands), or a number of diseases indicative of AIDS such as pneumocystis carinii pneumonia (PCP) or kaposi's sarcoma.<sup>127</sup> However, an individual may develop AIDS immediately without passing through any preliminary stage.<sup>128</sup> The rate of movement through each stage is not yet known.

AIDS is manifest in the form of several diseases including, PCP, and other bronchial infections, kaposi's sarcoma (skin cancer lesions), candidiasis of oesophagus or oral cavities (thrush or white patches of plaque or fungi on oral mucosa), cytomegalovirus retinitis (which can cause loss of vision), HIV wasting syndrome (chronic weight loss) and toxoplasmosis of the brain (a neurological abnormality).<sup>129</sup>

An individual may be infected with HIV but fail to develop any infection or other illness that fulfill the definition of AIDS. This is often referred to as a period of latency. Indeed, an individual may remain in this asymptomatic state with the virus laying dormant in his or her system for many years. Studies conducted in 1989 have revealed that HIV can remain dormant longer than previously thought. An period of up to approximately 10 years has been frequently suggested.<sup>130</sup> Such individuals pose a threat to the rest of society as

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<sup>126</sup> Tindall, *supra* note 118, at p. 71.

<sup>127</sup> PCP and kaposi's sarcoma form part of the current case definition of AIDS and were indicator diseases that formed part of AIDS Related Complex (ARC). ARC was a term used to denote indicator diseases of AIDS that were not symptomatic but laboratory indicated. The term was used in some older legislation in Australia, for example, *Diseases Notification Regulations* (1984)(Vic.); *Public and Environmental Health Act* (1987)(S.A.), well beyond 1987 when CDC abolished the ARC classification.

<sup>128</sup> Najera, R., and Herrera, M. I., 'Biology of the Virus', *World Health*, March 1988, 10-11. See also Isaksson, B., Albert, J., Chiodi, F., *et al*, 'AIDS - 2 Months after Primary HIV Infection', *J Infect Dis* 1988, 158/4:866-868, where a case-study of a patient who rapidly progressed to AIDS only two months from the date of infection is discussed. The authors conclude that the case is unique.

<sup>129</sup> Nash, G., and Said, J. (eds) *Pathology of AIDS and HIV Infection*, Philadelphia, W.B. Saunders, 1992.

<sup>130</sup> Bacchetti, P., and Ross, A. R., 'Incubation period of AIDS in San Francisco', *Nature* 1989, 338:251-253 and Hessol, N. Z., *et al*, 'The natural history of HIV infection in a cohort of homosexual and bisexual men: a decade of follow up', Presented at the IV International conference on AIDS - Stockholm, Sweden, June 1988. These studies have been confirmed by Nash, G., 'Spectrum of Infection', in Nash and Said (eds) *Ibid*, 8-10, at p. 9.

they are 'carriers' of the virus and in the absence of evidence to the contrary presumed infectious. It is not known why HIV discriminates in this manner. Studies are still being conducted to identify how the disease remains dormant. It is thought that an active immune system in some individuals prevents development.<sup>131</sup> It has been found that CD4+ T cells serve as a reservoir for latent HIV-1 viruses. These cells contain DNA sequences of HIV in 1/1000 cells. In patients with AIDS the proportion is 1/100, and such patients lose CD4+ T cells progressively as the disease advances and they become profoundly suppressed immunologically.<sup>132</sup> A further study has revealed that the human herpes virus 6 (HHV-6) can interact with HIV in a way that may increase the severity of HIV infection.<sup>133</sup> Tests have shown that if the T cell is infected with HHV-6 at the same time as HIV, it can activate the latent virus.<sup>134</sup>

#### **4. EPIDEMIOLOGICAL COMPARISONS BETWEEN HIV AND OTHER COMMUNICABLE DISEASES**

During the course of some prior epidemics of communicable disease restrictive legal measures have been set in place. It is to these legal procedures and policies that legislators have turned when considering the appropriate legal response to the emergence of HIV/AIDS. It is therefore necessary to briefly compare the characteristics of HIV/AIDS infection with diseases such as the plague, small-pox, yellow fever, cholera, tuberculosis (TB) and some of the sexually transmitted diseases (STDs) such as syphilis, herpes and hepatitis B (HBV). The listed diseases are all contagious. They are medically regarded as resulting from the invasion of a living stimulus such as a virus or bacteria and transmitted directly or indirectly through an infectious agent from one susceptible host to another.

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<sup>131</sup>Levy, *supra* note 74, at p. 28.

<sup>132</sup>Schnittman, S. M., Psallidopoulos, M. C., Lane, H. C., Thompson, L., Baseler, M., *et al*, 'The Reservoir for HIV-1 in Human Peripheral Blood is a T cell that Maintains Expression of CD4', *Science*, 1989, 245:305-307.

<sup>133</sup>Gallo and Montagnier had stated that 'HBV underlies the capacity of HIV to remain latent for a long period, then undergo a burst of replication ...' (*supra* note 68, at p. 29).

<sup>134</sup>Gallo and Montagnier, *ibid*, at p. 31 and Holmberg, S. D., Stewart, J. A., Gerber A. R., *et al*, 'Prior herpes simplex virus type 2 infection as a risk factor for HIV infection', *JAMA*, 1988, 259:1048-1050.

Although HIV/AIDS infection bears some similarity to these diseases, there are characteristics of HIV infection that renders alignment of AIDS with other diseases difficult. These medical features need to be focused on when considering the application of laws developed in a prior era of communicable diseases, to HIV/AIDS. The characteristics have been divided into three categories and will be briefly considered.

#### MODE AND EASE OF TRANSMISSION

HIV infection most commonly resembles those diseases primarily transmitted by sexual contact. Within that group, HIV shares similar modes of transmission and group prevalences to Hepatitis B (HBV). For example, like HIV, HBV is most commonly found in homosexuals, heterosexuals, IV drug users, blood and blood product recipients, health care workers and prostitutes.<sup>135</sup> More particularly it is found in those individuals with multiple sexual partners and those persons who share needles. Studies reveal that 10% of AIDS patients have evidence of past HBV infection.<sup>136</sup> However, HBV has been found to be ten times more infectious than HIV.<sup>137</sup> This is thought to be because there is a lower level of HIV in the blood than the level of HBV in the blood of an HBV-infected person and this is why the latter is more contagious.<sup>138</sup> Therefore, the risk of infectivity with HBV in needlestick injuries is higher than with HIV.<sup>139</sup> Further, HIV is not hardy and is readily susceptible to sterilisation and heating procedures.<sup>140</sup>

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<sup>135</sup> Ravenholt, R. T., 'Role of Hepatitis B Virus in Acquired Immunodeficiency Syndrome', *Lancet*, 1983, 2:885-886 at p. 885.

<sup>136</sup> Lebovics, E., and Dworkin, B. M., 'The Liver in AIDS', in Wormser Stahl and Bottone, *supra* note 71, at p. 76

<sup>137</sup> Giesecke, J., Scalia-Tomba, G., and Furucrona, A., 'HIV Infectivity - the Hepatitis B Lesson', *Scand J Infect Dis*, 1988, 20:385-387, at p. 386. Aller, M. J., and Francis, D. P., 'Hepatitis B Virus Transmission Among Homosexual Men: A Model for AIDS', in Pearl and Armstrong, *AIDS and Infections of Homosexual Men*, 2nd ed, Boston, Butterworths, 1989, 99-107.

<sup>138</sup> Levy, *supra* note 74, at p. 24.

<sup>139</sup> Shikala, T., Karasawa, T., Abe, K., *et al* 'Hepatitis Be antigen and infectivity of Hepatitis B virus', *J Infect Dis* 1977, 136:571-576.

<sup>140</sup> See *supra* note 106.

The pneumatic infections suffered by the patient during the course of HIV infection resemble infection with TB.<sup>141</sup> This has led to a demand by the public and by government officials to subject HIV-infected individuals to public health measures similar to those invoked to deal with TB decades ago.<sup>142</sup> However, the modes of transmissibility and group prevalences between TB and AIDS are not readily comparable. For example, HIV is not spread by social contact while TB is not spread peri- or neo-natally or through sexual intercourse as is HIV.<sup>143</sup> HIV is not as contagious as either airborne or bacterial viruses and cannot be spread by casual or social contact<sup>144</sup> which are all factors common to smallpox<sup>145</sup>, TB<sup>146</sup> and HBV.<sup>147</sup> In addition, HIV cannot be spread by contact

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<sup>141</sup> Duncanson, F. P., and Klein, N. C., 'Tuberculosis in AIDS', in Wormser Stahl and Bottone, *supra* note 71, at pp. 532-533.

<sup>142</sup> Exemplified in Wilson Tuckey's speech to delegates of Third National Conference on AIDS, in 'The Politics of AIDS: Wilson Tuckey's Address' (1988) 2/8 *National AIDS Bulletin*, 45-47 and referred to by Buchanan, D., 'AIDS Legal Workshop HIV testing: Principles and Policy' (1990) *National AIDS Bulletin*, July, 25-29, at p. 26 where he says it is a common phenomenon to relate HIV to TB in this manner.

<sup>143</sup> TB is arguably not inherited although it was and still is thought to be by many. Burnet and White refer to a study conducted on twins by Kallmann and Reisner, where a high percentage of TB was found in both the twins and to a lesser extent in their remaining family members, providing support to the scientist's hypothesis that TB may be inherited (at p. 216). If such a theory is a misconception it may have arisen because of the fact that infants born of parents suffering from TB, 'are very likely to be infected in the first months of life and die of a generalised tuberculosis in which the bacilli have passed to many parts of the body, especially the meninges of the brain ... [or] get into the blood ... and set up a new infection in one of the bones or joints, usually the 'spinal column or the hip' (Burnet, M., and White, D.O., *Natural History of Infectious Diseases*, 4th ed, London, Cambridge University Press, 1972, at pp. 214-215).

<sup>144</sup> Full Bibliographic details of these studies are contained in Lifson, *supra* note 79, at p. 1354-1356.

<sup>145</sup> Fenner, F., Henderson, D. A., Arita, L., *et al*, *Smallpox and its Eradication*, Geneva, World Health Organisation, 1988, 186-194.

<sup>146</sup> There are however, non-contagious forms of TB, such as extrapulmonary disease, primary pulmonary disease in children, bacteriologically unconfirmed pulmonary disease, and tuberculous infection. 'Use of BCG Vaccines in the Control of Tuberculosis: A Joint Statement by the ACIP and the Advisory ACIP Committee for Elimination of Tuberculosis', *JAMA* 1988, 260: 2983-2991.

<sup>147</sup> Centre for Disease Control, 'Hepatitis transmitted by a Human Bite', *MMWR*, 1974, 24. Robinson, W. S., 'Hepatitis B Virus', in Deinhardt, R., and J., (eds), *Viral Hepatitis: Laboratory and Clinical Science*, New York, Marcel Dekker Inc., 1983, 57-116, at p. 87. Evidence of lethal HBV infection passed by a dentist, is covered in a study by Shaw, F. E., Barrett, C. L., Hamm, R., *et al*, 'Lethal Outbreak of Hepatitis B in a Dental Practice', *JAMA* 1986, 255:3260-3264.

with contaminated food or water as is the case with cholera.<sup>148</sup> Further, HIV is not spread by either insect or rodent vectors as in yellow fever (mosquitoes)<sup>149</sup> and the plague (rodents).<sup>150</sup> Humans are the hosts and agents of transmission.

#### PERIOD OF TRANSMISSIBILITY, INCUBATION AND ASYMPTOMATIC STATE

HIV has no acute period of transmissibility or definitive period when the patient is contagious as is the case with the diseases of smallpox,<sup>151</sup> cholera,<sup>152</sup> and yellow fever.<sup>153</sup> This has often been a factor argued in support of quarantining persons with those diseases.

Communicable diseases are all characterised by both symptomatic and asymptomatic states. The latter, more commonly referred to as the 'carrier' state is common to those diseases having a long incubation period such as AIDS, TB,<sup>154</sup> HBV (sixty to ninety days<sup>155</sup>) and to those diseases where the victim can harbour the infectious virus, including herpes,<sup>156</sup> latent and tertiary

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<sup>148</sup> Gangarosa, E. J. and Mosley, W. L., 'Epidemiology and Surveillance of Cholera' in Barua, D., and Burrows, W., (eds) *Cholera*, Philadelphia, W.B. Saunders Company, 1974, 381-403, at p. 394.

<sup>149</sup> WHO, *Prevention and Control of Yellow Fever in Africa*, Belgium, World Health Organisation, 1986, 1-19.

<sup>150</sup> Burnet and White, *supra* note 137, at p. 225.

<sup>151</sup> Fenner, *supra* note 139, 186-194.

<sup>152</sup> Oseasohn, R. S., *et al*, 'Clinical and Bacteriological findings Among Families of Cholera Patients', *Lancet*, 1966, 340-342.

<sup>153</sup> WHO, *Prevention and Control of Yellow Fever in Africa*, *supra* note 143.

<sup>154</sup> Rosencranz, H. A., and Lavey, W. G., 'Treating Patients with Communicable Diseases: Limiting Liability for Physicians and Safeguarding the Public Health' (1987) 32 *Saint Louis University Law Journal*, 75-101.

<sup>155</sup> Robinson, W. S., 'Hepatitis B Virus', in Deinhardt and Deinhardt, *supra* note 140, at p. 91. Krugman, S., Overby, L. R., Mushahwar, I. K., *et al*, 'Viral Hepatitis, type B. Studies on Natural History and Prevention Re-Examined', *New Eng J Med*, 1979, 300:101-106.

<sup>156</sup> National Health and Medical Research Council, *Handbook on Sexually Transmitted Diseases*, Canberra, Australian Government Publishing Service, 1990, at pp. 33-34.

syphilis <sup>157</sup> and mild cholera.<sup>158</sup> The carrier therefore poses a threat to public health as he or she has the potential to unknowingly infect any given population.

#### AVAILABILITY OF A CURE

In general, treatment is available for the diseases referred to above and the patient is capable of full recovery provided the correct diagnosis is made and treatment implemented in time. However, with both Herpes and HIV/AIDS infection, although treatments are available there is no cure. A single exposure to smallpox, <sup>159</sup> yellow fever <sup>160</sup> and HBV <sup>161</sup> confers a life-long immunity on the sufferer. Conversely, with TB, <sup>162</sup> HIV/AIDS and the remaining STDs (herpes, <sup>163</sup> syphilis <sup>164</sup>) a patient may be infected for life or suffer recurrent episodes.

Death is presently the end stage of HIV infection that progresses to AIDS. Attention has been directed to the development of a vaccine but to date this has not been successful and is unlikely to be available until the year 2000. <sup>165</sup> At best there is only a drug treatment programme for HIV-infected persons, the effectiveness of which is currently in dispute. <sup>166</sup> Even the most favourable

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<sup>157</sup> *Ibid*, at p. 24.

<sup>158</sup> Sack, R. B., 'Pathogenesis and Pathophysiology of Diarrhoeal Diseases Caused by *Vibrio Cholerae* and Enterotoxigenic *Escherichia Coli*', in Ouchterlony, O., and Holmgren, J. (eds) *Cholera and Related Diarrheas*, Basel, S. Karger, 1980, at pp. 53-60.

<sup>159</sup> Fenner, *supra* note 139, 186-194.

<sup>160</sup> WHO, *supra* note 143, at p. 8.

<sup>161</sup> Lebovics and Dworkin, *supra* note 130, at p. 76. However, it is thought that 10% of patients will develop life-long infection (Aller and Francis, *supra* note 131, at p. 105).

<sup>162</sup> Barker, R., Burton, J. R., and Zieve, P. D., *Principles of Ambulatory Medicine*, 2nd ed, Baltimore, Williams & Wilkins, 1986, at pp. 370-371.

<sup>163</sup> Chang, T. W., 'Genital Herpes and Type 1 Herpes Virus Hominis', *JAMA*, 1977, 238:155-158.

<sup>164</sup> National Health and Medical Research Council, *supra* note 150, at p. 23.

<sup>165</sup> Esparza, J., and Osmanov, S., 'The development and evaluation of HIV vaccines', *Current Opinion in Infectious Diseases*, 1993, 6:218-229. American College of Physicians and Infectious Diseases Society of America, 'Human Immunodeficiency virus (HIV) Infection' *Ann Intern Med* 1994, 120:310-319, at p. 317.

<sup>166</sup> For example, the Concorde Trial conducted in France which tested 1,762 people between 1988 and 1991 found that the benefit of AZT therapy in asymptomatic HIV-1 infected individuals was transient. In addition, the increase in CD4+ counts which occurred in the group receiving immediate therapy, did not translate into a clinical benefit by the conclusion of the three year study (Aboulker, J. P., Stewart, A., 'A Preliminary Analysis of the Concorde Trial,' *Lancet*, 1993,

studies will find that the drug Ziduvodine (AZT) will prolong life for a minimal period only.<sup>167</sup> Alternative drugs available for the prevention and treatment of PCP have resulted in a decrease in the number of cases seen in medical centres in the United States.<sup>168</sup> Before such treatment was available PCP was by far the most common AIDS-defining illness encountered in HIV-positive patients.

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341:889-890). These findings are in contrast to the Australian-European Clinical Trial (Cooper, D., Gatell, J., Kronn, S., *et al*, 'Ziduvodine in Persons with Asymptomatic HIV Infection and CD4+ Cell Counts Greater than 400 per cubic Millimeter' *New Eng J Med*, 1993, 329:297-303) which found that the drug significantly reduced disease progression although it confirmed that the benefits were time limited. Therefore the value of AZT in early treatment remains uncertain.

<sup>167</sup> In a study by Pizzo, P., Eddy, J., *et al*, 'Effect of Continuous Intravenous Dosage of Azidovudine on Children with Human Immunodeficiency Virus (HIV)', *New Eng J Med* 1988, 319:889-896, it is concluded that AZT is beneficial in children with symptomatic HIV infection. A study conducted in Paris, concluded that the benefits of AZT are limited to a few months, six for ARC and AIDS patients and then only for certain patients (Dournon, E., Rosenbaum, W., Michon, C., *et al*, 'Effects of Zidovudine in 365 Consecutive Patients with AIDS or ARC', *Lancet*, December 3 1988, 2:1297-1302). Further, it appears that after 12 - 36 months of taking AZT people show increased viral resistance to the drugs (Fischl, M., 'Prolonged Zidovudine Therapy in Patients with AIDS and Advanced ARC Complex', *JAMA* 1989, 262:249). The value of these studies may be questionable now given the result of the Concorde Trials as set out in footnote 160.

<sup>168</sup> Sattler, F. R., 'Pulmonary Manifestations of AIDS: special emphasis on pneumocystosis', in Wyngaarden, J. B., Smith, L. H., Bennett, J. C. (eds) *Cecil Textbook of Medicine*, 19th ed, Philadelphia, W.B. Saunders, 1992, 1932-1942.

## CHAPTER 2

### THE ROLE OF THE CRIMINAL LAW IN THE CONTEXT OF AIDS

#### 1. INTRODUCTION

The emergence of the AIDS epidemic raises questions concerning the proper limits of legal control over the behaviour of individuals in society. The criminal law has been criticised for casting too wide a net over the private lives of members of society, with the result that decriminalisation or legalisation of conduct such as, but not limited to, homosexuality, prostitution and drug use has either been considered or implemented in many States of Australia <sup>1</sup> and other

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<sup>1</sup> In Australia, homosexual activity occurring in private has been decriminalised in all jurisdictions except Tasmania (s. 122-123 *Criminal Code* (1924). The relevant provisions are: South Australia since 1972 under s. 68A *Criminal Law Consolidation Act*, in New South Wales since 1984 under ss 78G-T of the *Crimes (Amendment) Act*; in Victoria under ss. 47-50 of the *Crimes (Sexual Offences) Act* (1980), in Western Australia in March 1990 under the *Law Reform (Decriminalisation of Sodomy) Act* (1989) which decriminalised homosexual activity between consenting adults (over twenty-one years in private) and in Queensland in 1990 under the *Criminal Code and Another Act Amendment Act*. In the remaining Code jurisdiction, the Northern Territory, homosexual activity occurring in public is stated to be illegal under section 127 of the *Criminal Code* (1983) (with the implication that activities occurring in private are not).

Prostitution-related activities are rendered offences in all Australian jurisdictions. Offences include: loitering and soliciting in a 'public place', living on the earnings of prostitution, procurement of children and adults for purposes of prostitution and offences connected with keeping, managing or assisting in the management of a brothel. These offences are contained in the following Acts: ss. 15-20 *Summary Offences Act* (1988) (N.S.W.), ss. 91A, B (procurement) and ss. 91C-F (child prostitution) *Crimes Act* (1958)(N.S.W.); ss. 8(1)(c), 8(1A)(2), 11, *Police Offences Act* (1935)(Tas.), ss. 128(b)-(d), 143 *Criminal Code* (Tas.); s. 10(1) (living on the earnings), 10(1A), 11(1) (keeping of a brothel not being one for which a permit has been obtained) *Vagrancy Act* (1966)(Vic.), s. 5 (soliciting), 6-9 (child prostitution) 10-11 (forcing adults into prostitution) *Prostitution Regulation Act* (1986)(Vic.); s. 10 *Prostitution Regulation Act* (1992)(A.C.T.); ss. 18A (soliciting), 18B (advertising prostitution), 18C (nuisances connected with prostitution) *Vagrants, Gaming and Other Offences Act* (1931-1978) (Qld.), ss. 217-218, 229G (procurement), 229H, I, K (premises used for prostitution) *Criminal Code* (1899)(Qld.); ss. 76F, 76G(1)(a)(b) *Police Act* (1892-1982)(WA); s. 63 *Criminal Law Consolidation Act* (1935)(SA), ss. 25(a)(b), 26(1), 28, 29 *Summary Offences Act* (1953)(SA); ss 47A(1)(2)(a) *Summary Offences Act* (1923)(N.T.), s 4,5 (management of brothels), 10 (soliciting), 11-12 (forcing adult into prostitution) *Prostitution Regulation Act* (1992)(N.T.). Victoria, in recognising the threat of the spread of HIV by prostitution, has attempted to regulate the industry by the passage of the *Prostitution Regulation Act* (1986) which tightens hygiene in light of AIDS (s. 13. yet to be proclaimed). The legislation establishes a licencing system for brothels and provides for planning controls of brothels (the latter is contained ss. 50-52 have been proclaimed). The 1992 *Prostitution Regulation Act* in the Northern Territory and the *Prostitution Act* in the Australian



countries.<sup>2</sup>

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Capital Territory also have a similar aim. In New South Wales, section 13(2) of the *Public Health Act* penalises the owner of premises who allows a prostitute known to be infected with HIV from engaging in sex without the consent of the client. The prostitute also commits an offence in those circumstances under section 11 of the same Act. The Legal Working Party of the Intergovernmental Committee on AIDS (IGCA) in its 1991 report entitled *HIV/AIDS: sex workers and their clients*, reiterate that laws criminalising sex industry work in brothels, escort agencies and on the street should be repealed. In addition, laws associated with the sex industry except for offences related to violence or coercion of minors should be repealed.

Drug use is illegal in all Australian States and Territories: (ss. 5 and 12(1) *Drugs Misuse and Trafficking Act* (1985)(N.S.W.); s. 31(1)(b) *Controlled Substances Act* (1984)(S.A.); s. 55(d) *Poisons Act* (1971)(Tas.); s. 75 *Drugs, Poisons and Controlled Substances Act* (1981)(Vic.); s. 6(2) *Misuse of Drugs Act* (1981)(W.A.); s. 171 *Drugs of Dependence Act* (1989)(A.C.T.); s. 13-14 *Misuse of Drugs Act* (1990)(N.T.)). Under the *Drugs Misuse Act* (1987)(Qld.) the self-administration of drugs is not criminal. However, under s. 9 of the same Act, possession is, and in a practical sense a user found in possession of a prohibited substance would commit an offence. There have been some legalisation of drug use in Australia. For example, in South Australia, under the *Controlled Substances (Expiation of Cannabis) Regulations* (1988) a person found in possession of less than 100 grams of cannabis is not convicted but completes an expiation notice and pays a fee in order to dispose of the offence. In 1989 Victoria decriminalised possession of cannabis in small quantities (s. 76 *Drugs, Poisons and controlled Substances Act* (1981)).

<sup>2</sup> In New Zealand, the *Homosexual Law Reform Act* (1986) removed criminal sanctions against consensual homosexual conduct between males of certain ages. In countries such as Spain, Italy and France homosexuality has been left to the conscience of the individual rather than covered by legislative controls (Waugh, M. A., 'History of clinical developments in sexually transmitted diseases', in Holmes, K. K., Mardh, P.-A., Sparling, P. F., et al, *Sexually Transmitted Diseases*, 2nd ed, New York McGraw-Hill, 1990, 3-16 at p. 14). In the United Kingdom, chapter 60 of the *Sexual Offences Act* (1967) removed homosexual relations between consenting adults in private from the sphere of the criminal law. Prior to this date homosexual conduct constituted an offence under both the *Offences Against the Person Act* (1861)(UK) and the *Vagrancy Act* (1898)(UK). The law in Northern Ireland was brought into line with that in England and Wales in 1981 following the ruling in *Dudgeon v United Kingdom* (1981) 3 EHRR 40. In February 1994 after vigorous debate from all interested parties the English House of Commons by a 265 majority reduced the age of consent for homosexual intercourse from 21 to 18 years. The amendment to equalise the age of consent for homosexual and heterosexual intercourse at 16 years, was rejected ('Yes to 18, No to 16' *The Guardian*, February 22nd 1994, at p. 1).

In 1962, the American Law Institute issued its *Model Penal Code* recommending decriminalisation of consensual private same-sex activities between adults (§ 213.2 note on status of section (Proposed Official Draft 1962)). This was followed by a movement towards challenging anti-gay administrative decisions in the late 1960s and early 1970s. However, sodomy remains a crime in nearly half of the United States (Anon, 'Developments in the Law: Sexual Orientation and the Law' (1989) 109 *Harvard Law Review*, 1508-161 at p. 1519; Tierney, T. W., 'Criminalising the Sexual Transmission of HIV: An International Analysis' (1992) 15 *Hastings International and Comparative Law Review*, 475 at p. 485). The United States Supreme Court in a 5-4 majority decision in *Bowers and Hardwick* (92 L.Ed. 2d 140 (1986), 478 US 186 (1986)), held that a Georgia State sodomy statute criminalising homosexual conduct (*Georgia Code Annotated* § 16-6-2 (1988)) did not violate the constitutional right to privacy and denied the applicants standing to challenge the constitutionality of the Georgia statute.

The issue of transmission of HIV has given rise to moral debates. This is due, in part, to the fact that HIV is primarily spread by certain sexual activities such as unprotected anal sex and the sharing of unsterile needles during IV drug use. In addition, statistics reveal that HIV infection has been and continues to be prevalent within certain sub-groups of the population such as homosexuals, drug users and prostitutes.<sup>3</sup> As a result members of these groups are often viewed by the general populace as high-risk for transmission of HIV on the ground that they are suspected to be engaging in high-risk activities such as unsafe sex and using non-sterile needles. Viewing HIV/AIDS in this context, the question whether the transmission of HIV should be expressly criminalised opens up the long-standing debate about the morality of activities such as homosexuality, prostitution and drug use.

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<sup>3</sup> The *Australian HIV Surveillance Report* for December 1993 provides statistics that support the view that the incidence of HIV/AIDS is still most commonly situated in the male homosexual/bisexual group. 83.3% of the total 4722 AIDS cases at that date are within that category (National Centre in HIV Epidemiology and Clinical Research, *Australian HIV Surveillance Report*, 1994, 10/2:12, Table 2.4).

HIV infection among prostitutes has not been effectively measured in all Australian States. The fact that they are a high-risk group is indicated by studies conducted into their patterns of safe-sexual behaviour carried out by Harcourt, C., Philpot, C. R., and Edwards, J., 'Human immunodeficiency virus infection in prostitutes', *Med J Aust* 1989, 150:540-541. However, the same study found a rise in condom use among prostitutes from 47.3% in 1986 to 84.9% by 1988. More recent studies conducted into the population of sex-workers in New South Wales have found that 70% of female prostitutes work in parlours and have responded most significantly to AIDS education campaigns. The greatest risk of HIV transmission is to found with the street workers (who form 10% of the population of female prostitutes) who have a high level of substance abuse (Egger, S., and Harcourt, C., 'Prostitution in New South Wales: The Impact of Deregulation', in Weiser-Easteal, P., and McKillop, S., (eds) *Women and the Law*, Canberra, Australian Institute of Criminology Proceedings, 1993) 109-122). It is significant that there is still no documented case of a female prostitute in Australia receiving or transmitting HIV infection during sexual intercourse with a client (Egger, at p. 112). A study by Lovejoy, F., Perkins, R., Corduff, Y., Deane, M. J., and Wade, A., *AIDS Preventative Practices Among Female Prostitutes and their Clients and Private Risk*, Part 1, University of New South Wales, 1991, 5 confirms this to be the case in New South Wales. This research also confirmed prior Australian research that there is a moderate number of prostitutes who inject prohibited substances. For example of 280 women, 5% injected amphetamines, 2.5 % injected cocaine and 9.3% injected heroin.

IV drug use is documented as high-risk for transmission of HIV. However, statistically in Australia this category represents 5.5% of the total 4722 cases as at December 1993 (*Australian HIV Surveillance Report* 1994, 10/2: 12, Table 2.4). It was stated in chapter one, that it is thought that these figures may not be an accurate indication of prevalence due to the possibility that an IV drug user might be categorised differently, for example, in the heterosexual transmission category.

In 1993 sex workers, IV drug users and homosexuals are still regarded as high-risk groups in Australia (Commonwealth of Australia, 1993-4 -1995-6 *National HIV/AIDS Strategy*, Canberra, Australian Government Publishing Service, 1993, at p. 22).

It is necessary to examine in detail how successful the criminal law has been in controlling activities that carry moral overtones, in particular, homosexuality, prostitution, and drug abuse. At first glance it may seem that the arguments for and against criminalising homosexual sex or drug use are different from the arguments for and against imposing liability for transmission of HIV. However, it is the present writer's contention that many of the same questions arise for consideration in both contexts. This is due, in part, to the fact that the effect of criminalising HIV transmission is likely to be felt more in a psychological, social and practical sense by those groups who are perceived to be at risk for transmission. Therefore, an analysis of the past usefulness of the criminal law in controlling activities such as homosexuality, drug use and prostitution must be of some assistance to lawmakers in determining whether the criminal law is the most appropriate tool with which to combat the spread of HIV/AIDS. In light of the criticisms directed at the criminal law in this area, it may not be appropriate to impose criminal liability by the use of traditional criminal laws on those who spread HIV when engaging in sexual behaviour or needle sharing except in limited circumstances.

This chapter introduces the aims of the criminal law. Following this the arguments for and against the use of the criminal law in eradicating or controlling the incidence of, for example, homosexuality, prostitution and drug use will be considered in relation to the aims of the criminal law. The issue of whether these aims can be served by criminalising the transmission of HIV will be covered. In this context, the question of whether the criminal law could have some other function such as establishing symbolic values, attitudes and beliefs in relation to HIV/AIDS will also be considered.

## **2. THE AIMS OF THE CRIMINAL LAW**

One of the unsettled issues in the criminal law has been what its aims are or should be. The aims of the law in general are expressed to be: maintenance of public order, upholding of rights and duties, facilitating co-operative action, conferring legitimacy and communicating moral standards.<sup>4</sup> However, the aims of the law may differ depending upon from whose viewpoint

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<sup>4</sup> Broom, L. and Selznick, P., *Sociology: A Text with Adapted Readings*, New York, Harper and Row, 1977, at pp. 408-410.

they are examined. For example, from a lawyer's point of view the aims of the law include the allocation of authority, the settling of disputes and the definition of relationships within society.<sup>5</sup> For the law reformer, the aims of the law are to educate and to facilitate social change.

Generally, three main aims of the criminal law can be identified, namely the protection of private property, the enforcement of morality and the prevention of harm to others.<sup>6</sup> It is the order of priority of these aims that has given rise to debate historically.<sup>7</sup> In common with the aims of the law in general, the criminal law also seeks to influence public opinion, maintain public order and communicate moral standards.<sup>8</sup>

At least two commentators have argued that the aims of the criminal law are deterrence, retribution, incapacitation and rehabilitation.<sup>9</sup> In the view of the present writer, these are the aims of punishment. While crime and punishment form an inseparable duo, deterrence, retribution, incapacitation and rehabilitation are more relevant to discussions pertaining to punishment, and thus have been discussed under sentencing of HIV-infected persons in chapter six.

The notion of protection of private property as an aim of the criminal law is easy to support and is not an issue relating to the control of AIDS. However, the other two aims, the enforcement of morality, and the prevention of harm, are more controversial and require elaboration in order to determine whether criminalising the transmission of HIV serves those aims.

The exact role that morality should play in shaping the criminal law has been hotly debated. Three different but often interrelated positions can be isolated within this debate.

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<sup>5</sup> Confirmed by Farrar, J. and Dugdale, A. M., *Introduction to Legal Method*, London, Sweet and Maxwell, 1984, at pp. 5-6 where they hold that law maintains public order, facilitates co-operative action, constitutes and regulates the principle organs of power and communicates and reinforces social values.

<sup>6</sup> Broom and Selznick, *supra* note 4, at pp. 408-410.

<sup>7</sup> the debate is considered in this thesis *infra*.

<sup>8</sup> Farrar and Dugdale, *supra* note 5, at pp. 5-6.

<sup>9</sup> Gostin, L., 'The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties' (1989) 49 *Ohio State Law Journal*, 1017-1058; Burris, S., Dalton, H. Miller, J.L., and the Yale AIDS Law Project, (eds) *AIDS Law Today: A New Guide for the Public*, 2nd ed, New Haven, Yale University, 1993, at pp. 251-252.

The first is the fundamentalist approach which encompasses the views of Sir James Fitzjames Stephen and Lord Devlin. For fundamentalists the enforcement of morality is the overriding aim of the criminal law.<sup>10</sup> By contrast the second approach encompasses the views of Mill and later H.L.A. Hart which is here labelled as a combined utilitarian - liberal view. This view supports the harm principle; that prevention of harm to *others* is the overriding aim of the criminal law.<sup>11</sup> The third approach described as Legal Paternalism sees the aim of the criminal law as principally the prevention of harm to the *actor* him or herself.<sup>12</sup> In that respect, the State has a right to intervene to protect the agent from harm.<sup>13</sup>

The debate between the fundamentalists and the utilitarianists/liberals, came to a head in the 1960s following the release of the Report by the Wolfenden Commission of their inquiry into the criminalisation of prostitution and homosexuality in the late 1950s.<sup>14</sup> The Committee by a majority of twelve to one recommended that penalties for homosexual activities between consenting adults in private be abolished. This recommendation received legislative effect by the English *Sexual Offences Act* (1967)(UK).

According to the majority of the Commissioners,

Unless a deliberate attempt is to be made by society, acting through the agency of the law, to equate the sphere of crime with that of sin, there must remain a realm of private morality and immorality which is ... not the law's business. To say this is not to condone or encourage private immorality.<sup>15</sup>

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<sup>10</sup> Devlin's thesis is contained in *The Enforcement of Morals*, London, Oxford University Press, 1965, Chapter 1, 1-26.

<sup>11</sup> Hart, H. L. A., *Law, Liberty and Morality*, London, Oxford University Press, 1962 at p. 5 and Mill, J. S., *On Liberty*, 2nd ed, London, J. W. Parker & Son, 1859 at pp. 15 and 18-19. Hart points out that he does not defend all that Mill said since Hart believes that there are grounds other than prevention of harm justifying the legal coercion of the individual. He stated: 'But on the narrower issue of enforcement of morality, Mill seems to be right' (at p. 5).

<sup>12</sup> It may well be the case that there are few if any examples where conduct harms only the doer of the act and not others. At this point the present writer merely seeks to draw a distinction between the harm to others and harm to self doctrines as rationales for laws.

<sup>13</sup> Feinberg, J., *Harm to Others: The Moral Limits of the Criminal Law*, Vol. 1, Oxford, Oxford University Press, 1984, at p. 12.

<sup>14</sup> Home Office, Scottish Home Department "Report of the Committee on Homosexual Offences and Prostitution" (Wolfenden Report) (Cmnd 247) London, 1957.

<sup>15</sup> *Ibid*, at para. 61.

At approximately the same time the House of Lords in *Shaw v DPP*<sup>16</sup> handed down a judgement which recognised the crime of 'conspiracy to corrupt public morals'. This provoked comments from both academic and judicial quarters including responses from both Hart and Devlin.<sup>17</sup> The essence of the judgement of Viscount Simonds is that courts had a residual power to create crimes to protect 'not only the safety and order but also the moral welfare of the state' where no statute had covered that particular area.<sup>18</sup> In a dissenting judgement, Lord Reid argued that apart from the fact that there was no such thing as a conspiracy to corrupt public morals because a conspiracy required two or more persons, he believed that Parliament was the only place where crimes could be established and that Judges could not invent dubious crimes from historical sources.<sup>19</sup> 'When there is sufficient support from public opinion, Parliament does not hesitate to intervene. Where Parliament fears to tread it is not for the courts to rush in.'<sup>20</sup>

H.L.A. Hart criticised Lord Simond's approach in *Shaw* on two grounds. The first ground is that the decision would allow individual values of judges and juries to be imprinted upon society in condemning conduct as criminal. The second is that it showed disregard for the principle of legality, which requires criminal offences to be defined as precisely as possible.<sup>21</sup> To the contrary, Lord Devlin believed that it was a proper function of courts to enforce morality and for juries to be involved in the enforcement.<sup>22</sup> The views of both Hart and Devlin in general will be identified when examining what the aims of the criminal law are or should be.

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<sup>16</sup> [1961] 2 All ER 446.

<sup>17</sup> Devlin, *supra* note 10. Hart, *supra* note 11.

<sup>18</sup> [1961] 2 All ER 446, at p. 455.

<sup>19</sup> *Ibid*, at pp. 458-459.

<sup>20</sup> *Ibid*, at p. 457.

<sup>21</sup> Hart, *supra* note 11, at pp. 7-12.

<sup>22</sup> in *The Enforcement of Morals*, *supra* note 10, at p. 21.

## THE ENFORCEMENT OF MORALITY THROUGH THE CRIMINAL LAW

A number of arguments often proffered in favour of the use of the criminal law in the enforcement of morality will be examined. They include the need to protect a common morality, prevent social disintegration, the requirement for the criminal law to set moral standards as a symbol, and the role of the criminal law as the educator of public morality.

### (i) Protection of Common Morality

Fundamentalists such as Stephen and Devlin support the enforcement of a common morality through the criminal law. They believe that the criminal law is the protector and defender of moral values.<sup>23</sup> Although for the fundamentalists the main aim of the criminal law is the enforcement of individual morality, they also appear concerned with moral harm to the community. Within this approach, Stephen presents what may be termed a moral absolutist argument. 'The criminal law should not only be used for protection against acts dangerous to society but as a persecution of the grosser forms of vice.'<sup>24</sup> What Stephen means is that whatever is immoral should be sanctioned by the criminal law irrespective of established harm to an individual or society.<sup>25</sup>

Devlin takes a somewhat different stance. Although he rejects Stephen's view<sup>26</sup> that the criminal law exists to promote virtue among its citizens, he believes that any community could exist only if it had a certain sense of right and wrong and legal institutions had to represent the moral sense of the community. To this end he makes it clear that sexual aberrations are monstrous

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<sup>23</sup> Friedmann, W., *Law in a Changing Society*, 2nd ed, Harmondsworth, Penguin, 1972, at p. 192.

<sup>24</sup> Stephen, J. F., *Liberty, Equality, Fraternity*, 2nd ed, London, Smith Elgard & Co., 1874, at p. 162.

<sup>25</sup> Hart' sets out his view of the difference between Stephen and Devlin. He states: 'We may ask first, Does this act harm anyone independently of its repercussion on the shared morality of society? And secondly we may ask, Does this act affect the shared morality and thereby weaken society? The moderate thesis [Devlin's] requires, if the punishment of the act is to be justified, an affirmative answer at least at the second level. The extreme thesis [Stephen's] does not require an affirmative answer at either level' (*supra* note 11, at pp. 49-50).

<sup>26</sup> Stephen, *supra* note 24, at p. 159.

sins. Given the fact that Devlin's view was expressed at the same time as the release of the Wolfenden Commission Report, it is not surprising that he tends to confine concepts of morality to the sphere of sex and sexual offences. He emphasises the outrage to the moral sense of the community as the rationale for the intervention of the criminal law. Thus the injured citizen is the morally zealous bystander, not the person at whom the act is directed.

The views of Stephen and Devlin coincide where they both argue that the fact an action is generally regarded as immoral in itself is at least a sufficient reason, if not a good one, for it to be made a crime.

## (ii) Prevention of Social Disintegration

In Devlin's opinion, the protection of a common morality and prevention of social disintegration are inextricably linked, as he views the failure to observe common morality as leading to social disintegration and harm to society.<sup>27</sup> Control of personal freedom Devlin argues, is necessary for a well-ordered society which gives the State the right to legislate against immorality.<sup>28</sup> His argument favours the harm principle but the harm is to the social order rather than the individual.

[A]n established morality is as necessary as a good government to the welfare of society ... There is disintegration when no common morality is observed ... so that society is justified in taking the same steps to preserve its moral code as it does to preserve its government and other essential institutions. The suppression of vice is as much the law's business as the suppression of subversive activity.<sup>29</sup>

While it is true that the notion of the smooth functioning of society underlies most penal laws, for example, public disturbances, theft and personal attacks<sup>30</sup> the

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<sup>27</sup> Devlin, *supra* note 10, at p. 10.

<sup>28</sup> *Ibid*, at pp. 10-14.

<sup>29</sup> *Ibid*, at p. 13.

<sup>30</sup> *Ibid*, at p. 23.



need to uphold the smooth functioning of society does not require that the law interfere in all sexual behaviour.<sup>31</sup>

However, Devlin disagreed with the Wolfenden Commission's recommendation that homosexual activity occurring in private should be decriminalised.<sup>32</sup> He believed that if homosexual acts arouse such general abhorrence that they in fact threaten social disintegration, this gives the criminal law the right to intervene in the private lives of citizens by penalising such conduct.

Hart argued against Devlin's belief that the loosening of moral bonds is often the first stage of social disintegration. According to Hart, 'no evidence is produced to show that deviation from accepted sexual morality, even by adults in private, is something which, ... threatens the existence of society.'<sup>33</sup> It is the present writer's view that Devlin's disintegration thesis is in fact a theory which argues that morality should be enforced whether or not immorality itself causes any harm.

### (iii) Symbolic Value of the Criminal Law

The drafting and enactment of what might be termed 'symbolic' legislation does not take into account whether the legislation can in fact be enforced. In such circumstances, the aim of the law seems to be to proscribe particular moral principles in private life irrespective of whether the offender's act can be shown to cause harm to others or even to him or herself. The law is used to set standards of acceptable social morality as a symbol. Symbolic legislation can be distinguished from educative legislation on the ground that there is no serious legislative intention of producing significant social change by means of the former. Rather, the object is to placate certain sections of society demanding it. 'Knee-jerk' or reactionary legislation can fall within this category.

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<sup>31</sup> Ten, C. L., 'Crime and Immorality' (1969) 32 *Modern Law Review*, 648-663, at pp. 658-659.

<sup>32</sup> He has since indicated that he is not in favour of criminalising homosexual acts in private (Harris, J., *Legal Philosophies*, Butterworths, London, 1980, at p. 124).

<sup>33</sup> Hart, *supra* note 11, at p. 50. This is supported by Ten (*supra* note 31, at p. 661), who also remarks that Devlin provides no evidence that immorality threatens the common morality or that certain legislation leads to a decline in morality, and by Dworkin, R., 'Lord Devlin and the Enforcement of Morals' from Wasserstrom, R. A. (ed), *Morality and the Law*, California, Wadsworth Publishing Company, 55-72 at p. 59.

The main reason behind the use of such symbolic legislation was aptly put by those in the Wolfenden Commission who were against the decriminalisation of both homosexuality and prostitution. They believed that leaving unenforceable crimes on the statute books may act as a deterrent for some who might otherwise commit them, or alternatively their existence may be seen as a declaration of what society condemns.<sup>34</sup>

This position is reflected in the arguments that have been advanced by other writers against the decriminalisation of homosexuality. Some have commented that decriminalisation would lead to an increase in the molestation of minors. But, molestation is not the province of homosexuals exclusively. It is prevalent among heterosexuals, more often aimed at girls by males and commonly occurs within the family unit.<sup>35</sup> Alternatively, opponents argue that decriminalisation of homosexuality would result in many more people leaning toward this conduct as it is an acceptable form of social behaviour. Packer supports this view.

When the threat of punishment is removed or reduced, either through legislative repeal or (as ordinarily occurs) through the inaction of enforcement authorities, conduct that has previously been repressed ... tends to increase ... not merely because people feel that a threat has been removed but also, and probably more significantly, because the subtle process of value reinforcement through the rites of criminal stigmatization comes to a stop.<sup>36</sup>

Whether this has been the case following decriminalisation of homosexual conduct in Australia is open to debate, given that there is no sound statistical evidence from which to clarify the point. Given the fact that a high percentage of HIV-infected persons fell within the homosexual/bi-sexual group in Western Australia, Queensland and Tasmania,<sup>37</sup> the States that still criminalised homosexual conduct in private prior to January 1990 it is arguable that criminal

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<sup>34</sup> Wolfenden Report, *supra* note 14, Mr Adair at para. 61.

<sup>35</sup> Tasmanian Law Reform Commission, *Report on Victimless Crime*, 1978, para. 6.9.

<sup>36</sup> Packer, H. L., *The Limits of the Criminal Sanction*, Stanford, Stanford University Press, 1968, at p. 109.

<sup>37</sup> *Communicable Diseases Intelligence Bulletin*, 1990, 8: 11.

provisions in force to that date have not deterred homosexuals from engaging in prohibited behaviour. If this is true then it is doubtful that the criminal law has successfully enforced morality (if it is immoral to engage in homosexual conduct).

However, it can be argued that decriminalisation does not result in an increase in the incidence of the relevant behaviour. The situation that Packer foresees resulting from decriminalisation, does not have to occur if the conduct is discouraged by education outside of the law. But, even education may not control sexual preferences. There is evidence to suggest that sexual preferences are determined by complex psychological and physical processes and the law is essentially irrelevant in this regard. '[S]exuality is a powerful force, subject to individual will but not completely so.' <sup>38</sup>

The argument that symbolic legislation has a deterrent effect is not well supported by experience. While acknowledging that it is difficult to measure deterrence, experience reveals that punishments have had no significant deterrent effect on the drug addict. <sup>39</sup> This may be due to the fact that laws prohibiting drug usage have not been strictly enforced (although prosecutions are considerably more common than for either homosexuality or prostitution). <sup>40</sup> Further, the deterrence argument ignores the variety of reasons that people turn to drugs and the fact that their addiction can control them and in turn deny the capacity to act rationally. <sup>41</sup>

Likewise, prostitution has persisted through all civilisations and has flourished regardless of laws. Throughout time, nations have used prostitution for their own ends. <sup>42</sup> The law has failed to enforce morality through the

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<sup>38</sup> Brandt, A. M., 'AIDS From Social History to Social Policy', in Fee, E., and Fox, D. M. (eds), *AIDS: The Burdens of History*, Berkeley, University of California Press, 1988, 141-171 at p. 152.

<sup>39</sup> Goode, E., 'The Criminology of Drugs and Drug Use', in Blumberg, A. S. (ed), *Current Perspectives on Criminal Behavior: Original Essays in Criminology*, New York, Knopf, 1974, 165-191 at pp. 181-182. Whether such legislation may have deterred others from taking up drug use is uncertain there being no published studies in Australia on this topic. On a related point, there has been little research to determine what the relative contributions of policy, prevention or treatments measures have been on the decreasing incidence of tobacco and alcohol use in Australia.

<sup>40</sup> Dobinson, I., Polietti, P., *Buying and Selling Heroin: A Study of Heroin Use/Dealers*, NSW Bureau of Crime Statistics and Research, 1987.

<sup>41</sup> Cohen, S., *Delinquent Boys: The Culture of the Gang*, Glencoe, Free Press, 1955, 59.

<sup>42</sup> See Bresler, F., *Sex and the Law*, London, Frederick Muller, 1989, 3-63; Daniels, K., *So Much Hard Work* Sydney, Fontana Books, 1984.

criminalisation of prostitution for two reasons both of which support the need to decriminalise and regulate the industry. The first reason is that sexual habits cannot be controlled through legal intervention. Some people have negative attitudes towards certain sex norms which may render it impossible to ever regulate or abolish prostitution. Second, as English legislators recognised in the 1860s, 'as long as there are men, there would be a demand; so long as there was a market, there would be a supply.'<sup>43</sup> If the client was removed the demand for prostitution would cease. The need for easy money and drugs in turn promotes the supply of prostitution.<sup>44</sup>

Viewed from this perspective, the symbolic argument as applied to criminal legislation has a tendency to be used to provide justifications for laws that are at best revenue raisers. This can be seen with laws pertaining to homosexual conduct, prostitution and drug use. Their enforcement is not successful but their presence on the statute books indicates that the activities are not tolerated. In addition, the policy of fines provides revenue. Ideological considerations prevent legislators seeing that 'efforts to stamp out crime actually strengthen it ...,' they cannot stand the "deviant" beating "the system", and public funds need the fines; criminalisation of [these activities] provides persons with jobs'.<sup>45</sup>

#### (iv) Educational Role of the Criminal Law

Even though the criminal law contains instances of symbolism which is simply meant to convey core social values (even if the same are not generally those of the populace) the criminal law does aim to be educative in nature, that is, there is some intent to produce social change or influence public opinion or both. There is no doubt that for a social change to occur there must be some effect on public opinion.<sup>46</sup> The precise role that the law should play

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<sup>43</sup> Porter, D., and R., 'The Enforcement of Health: The British Debate', in Fee and Fox, *supra* note 38, 97-120 at p. 105.

<sup>44</sup> Bresler, *supra* note 42, at p. 13.

<sup>45</sup> Goode, *supra* note 39, at p. 183.

<sup>46</sup> Tomasic, R., (ed), *Legislation and Society in Australia*, Sydney, Law Foundation of New South Wales and George Allen and Unwin, 1979, at p. 25.

and does play in this regard is also a source of debate. As the Wolfenden Commission observed,

On the one hand it is held that the law ought to follow behind public opinion, so that the law can count on the support of the community as a whole. On the other hand, it is held that a necessary purpose of the law is to lead or fortify public opinion. Certainly it is clear that if any legal enactment is markedly out of tune with public opinion it will quickly fall into disrepute.<sup>47</sup>

Clearly, legal moralists like Devlin and Stephen would support legislation that aimed to educate the public in the sphere of morality even if it involved a criminal penalty as part of its education. However, the fact that the law seeks to penalise some conduct may lead to the public forming adverse opinions as to the morality of that form of conduct. For example, American society has been defined as homophobic.<sup>48</sup> This may be because for the last two to three generations homosexuality has been and still is illegal in nearly half the American States.<sup>49</sup> The view that homosexual conduct is immoral has been handed down through generations. Similarly, in relation to drug laws, legislators and agents of the criminal justice system believe they enforce drug laws because drug use is "dangerous". The imputation of danger in actuality follows the belief that the use of certain drugs is wrong or evil. The public do not believe a drug should be criminalised because it is dangerous; they believe it is dangerous partly because they think it is immoral to use it and partly because the use of the drug is illegal.<sup>50</sup> In effect, a "rational" argument is superimposed on what is

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<sup>47</sup> Wolfenden Commission, *supra* note 14, at para. 16.

<sup>48</sup> Kohler, M. F., 'History, Homosexuals and Homophobia: the Judicial Intolerance of Bowers and Hardwick,' (1986) 19 *Connecticut Law Review*, 129-142 at pp. 130-131.

<sup>49</sup> The States are listed in 'Developments in the Law: Sexual Orientation and the Law' (1989) 102 *Harvard Law Review*, 1508-1671, at p. 1519; Tierney, T. W., 'Criminalising the Sexual Transmission of HIV: An International Analysis' (1992) 15 *Hastings International and Comparative Law Review*, 475 at p. 485.

<sup>50</sup> Richards, D. A. J., 'Towards New Perspectives on Drug Control: A Negotiated Settlement to the War on Drugs' (1987) 11 *Nova Law Review*, 909-913. Husak, D., *Drugs and Rights*, Cambridge, Cambridge University Press. 1992, p. 57.

essentially a moral and ideological conviction ...'.<sup>51</sup> In this way the criminal law imposes a view on society of what type of criminal is morally bad.

A number of arguments can be raised against the enforcement of morality being elevated as the overriding aim of the criminal law. These arguments will be considered in turn.

(i) The Intrinsic Problem of Identifying a Common Morality

Even Lord Devlin realised that it was almost impossible to ascertain the moral judgements of society yet he went on to state that the criminal law had to enforce the common morality.<sup>52</sup> Common morality depended upon the collective wisdom of reasonable men.<sup>53</sup> Criticism has been directed at this part of his thesis on the ground that the reasonable man has been devoid of accurate definition.<sup>54</sup> As one writer has stated: 'the reasonable man [sic] if he exists at all, may be a bundle of prejudices, ignorances and unresolved conflicts.'<sup>55</sup>

The difficulty with arguing that the criminal law should and does enforce morality is that the scope of prohibited conduct depends on changing values. The fact that in 1960 many people such as Devlin and Hart began to consider whether law should concern itself with private morals was fundamentally because it was becoming clear that there was no single clear moral code. Those in the minority in the Wolfenden Commission who called for the retention of homosexual offences on grounds of their symbolic value, i.e. that their retention would indicate what society condemns, have one major flaw in their argument. In a pluralist society it is difficult to ascertain what society generally condemns or to identify a common morality. For example, older people raised in a more

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<sup>51</sup> Goode, *supra* note 39, at p. 177. The dramatic shifts in the public perception of drug use in 18th-19th century America are covered in Duster, T. S., *The Legislation of Morality; law, drugs and moral judgment*, New York, Free Press, 1970, at pp. 3-23.

<sup>52</sup> Devlin, *supra* note 10, at pp. 4-5; 8-9.

<sup>53</sup> *Ibid.*, at p. 15.

<sup>54</sup> Blom-Cooper, L., and Drewry, G., *Law and Morality*, London, Duckworth, 1976 referring to the work of Sigmund Freud at p. 3.

<sup>55</sup> Lloyd, D., *Idea of Law*, Harmondsworth, Penguin, 1987 at p. 61.

restrictive atmosphere may abhor pornography peddlers whereas younger people may be indifferent to them.

This change in social morality was in fact one of Hart's criticisms of Devlin's thesis. Even if Devlin was correct as to his disintegration theory, it was not clear to Hart that moral sentiments against homosexuality were a necessary part of these shared moral beliefs. The possibility of temporal changes in moral views is a factor that Devlin ignored.<sup>56</sup> The very initiation of the Wolfenden Commission indicates that there may have been a greater degree of permissiveness becoming evident within English society in relation to homosexuality. Indeed, if it is true that society consists of a complex set of moral ideas which its members hold at a particular moment in time, 'it is intolerable that each such moral status quo should have the right to preserve its precarious existence by force.'<sup>57</sup>

Changes in views as to what is moral and immoral have been the impetus in the movement towards decriminalisation and legalisation of not only homosexuality, but also other 'victimless'<sup>58</sup> crimes such as prostitution and drug use. In fact, changing attitudes and social conditions have led to the abolition of conduct formerly condemned as criminal including homosexuality and abortion. This exemplifies a change in social morality; or at least a change in permissible sexual behaviour.<sup>59</sup> It also illustrates again that a common morality is hard to find.

Increasingly, morality has become the preserve of the individual, making responsible choices in the knowledge of the consequences of actions and regard for the well-being of those affected. The 'common morality' of a liberal democratic society in the 1990s may in fact require that we leave sufficient moral space for people to choose and not be coerced. As it is

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<sup>56</sup> Hart, *supra* note 11, at p. 51. In fact, Devlin commented '... moral standards do not shift ... but the extent to which society will tolerate ... departures from moral standards varies from generation to generation' (*supra* note 10, at p. 18).

<sup>57</sup> Dworkin paraphrasing Hart *supra* note 33, at p. 244.

<sup>58</sup> The Tasmanian Law Reform Commission, *supra* note 35, at para. 2.16 doubted whether there was in reality such a thing as a 'victimless crime' since almost any activity in which a person engages has repercussions for him or herself, his or her family, employment or society at large. Schur, considers that crimes without victims are those crimes where at least no one would recognise himself as a victim (Schur, E. M., *Crimes Without Victims: Deviant Behavior and Public Policy*, Englewood Cliffs, Prentice Hall, 1965).

<sup>59</sup> Friedmann, *supra* note 23, at pp. 200-201.

recognised that many of the laws express social attitudes of previous centuries and do not necessarily represent the social attitudes of today, pressure groups may seek to influence governments towards decriminalisation and legalisation of victimless crimes. This may lead governments to decriminalise selected offences to placate certain sections of society.

In the late 1980s Australians appeared divided as to whether homosexual conduct was moral or immoral or perhaps more appropriately, whether it was deserving of punishment or not. Acknowledging the sampling problems of public opinion polls, a September 1989 Morgan Gallop Poll of approximately 1,000 Australians showed that a clear majority supported decriminalisation of provisions penalising homosexual activities. For example, 74% of West Australians and 56% of Queenslanders supported decriminalisation, but only 47% of Tasmanians did. The percentage of persons supporting decriminalisation had risen 4% since 1974 when the last Morgan Gallop Poll was taken. However, there was also an 8% increase in those persons advocating that homosexual acts remain illegal.<sup>60</sup> The result is of some importance because it reveals that irrespective of the presence of HIV a significant proportion of the persons polled favoured the decriminalisation of homosexuality.

## (ii) The Problem of a Critical Morality

The fact that many forms of behaviour which involve sexual activity such as homosexuality and prostitution are regarded as immoral give rise to the concept of 'positive morality'. Positive morality is a term used to refer to the moral code in existence at a given time.<sup>61</sup> Hart distinguishes positive morality from more general moral principles used to assess whether any action is good or bad or right or wrong. These principles according to Hart, constitute 'critical morality'.<sup>62</sup> Critical morality can be used to assess positive morality and might be used to criticise a society whose positive morality treated homosexual activity as immoral. It is one thing to say that certain conduct breaches positive morality. It is a different thing to say that such conduct ought to be prohibited by the criminal law.

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<sup>60</sup> Murphy, K., 'What you think', *The Bulletin*, October 10 1989, 56-57.

<sup>61</sup> A term used both by Hart (*supra* note 11, at pp. 13, 17-20) and Feinberg, J., (*Rights, Justice and the Bounds of Liberty*, New Jersey, Princeton University Press, 1980, at p. 80).

<sup>62</sup> Hart, *supra* note 11, at p. 13, 17-20.



Imposing criminal liability in accordance with positive morality is dangerous given that positive morality is based on public opinion which may itself be wrong. Alternatively the perception of what the public condemn may have been incorrectly ascertained. It may be difficult to establish with any degree of certainty the percentage of a population who adhere to a particular view with respect to certain behaviour. For example, one could guess that few would take issue with the fact that torture and murder offends common moral standards, but, it would be difficult to assess what the public in general felt about homosexuality. The support for the former may be due to the overriding belief in the sanctity of human life and the abhorrence of unnecessary cruel and inhuman treatment.

It is Hart's view as it was Bentham's before him, that more harm may be caused to a community's values at large in enforcing a particular moral position.<sup>63</sup> Jeremy Bentham writing in the eighteenth century believed that the criminal sanction should not be used to support some vague standard of morality. 'The criminal law should not be used to penalise behaviour which does no harm.'<sup>64</sup> He believed that the criminal law should not be used to achieve a purpose which could be achieved as effectively at less cost in suffering, or where the harm done by the penalty was greater than the harm done by the offence.

There are a number of examples that can be cited that would tend to show that strong moral disapproval does not necessary imply that there should be a law criminalising the activity. Indeed sometimes the attempt to enforce morality is self-defeating.

For example, it is often argued that although homosexuality and prostitution may be immoral or undesirable, criminalisation produces more harm.<sup>65</sup> Victimless crimes 'often generate illegal behaviour and corruption on the part of police in their zeal to enforce the unenforceable'.<sup>66</sup> Corruption of law enforcement officials has been most evident in prostitution and has been aired in

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<sup>63</sup> *Ibid*, at p. 27.

<sup>64</sup> Bentham, J., *An Introduction to the Principles of Morals and Legislation*, 1789 cited in Walker, N., *Punishment, Danger and Stigma: The Morality of Criminal Justice*, Oxford, Basil Blackwell, 1980, at pp. 5-6.

<sup>65</sup> Hart, *supra* note 11, at p. 27.

<sup>66</sup> Blumberg, *supra* note 39, at p. 23.

Australia through the Royal Commission Inquiry into Possible Illegal Activities and Associated Police Misconduct (the 'Fitzgerald Inquiry') in Queensland.<sup>67</sup>

If only a small proportion of homosexual crimes can be proven against the perpetrators then the prohibition should not be included in the statute books, because doing so brings the law into disrepute. Leaving unenforceable crime on the statute books is dangerous since it encourages secondary crime such as blackmail and extortion.<sup>68</sup> A study in Sydney has shown that until 1987 only a very small proportion of drug-related crimes resulted in charges or convictions.<sup>69</sup> Random enforcement can have undesirable effects and is objectionable on the grounds of fairness.

There are further reasons why the criminalisation of neither drug usage nor prostitution can be commended. In relation to drug use, punitive policies have worsened the drug problem.<sup>70</sup> Admittedly there is very little empirical evidence on which to base such an assertion, but it appears that a decade of law enforcement in Australia at least has not reduced the number of heroin users markedly. An addict subculture has surfaced accompanied by criminal activity on the addict's behalf. An Australian study reveals that property crime is predominantly motivated by the desire for heroin.<sup>71</sup> Similar arguments can be raised when considering prostitution. One of the commonly advanced claims against the regulation of prostitution are that it implies moral approval. Women are seen as persons who need rehabilitation and society 'senses the seeds of social collapse in promiscuous, commercialised and uncontrolled sexual

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<sup>67</sup> Commission of Inquiry Pursuant to Order in Council, *Commission of Inquiry into Possible Illegal Activities and Associated Police Misconduct* (The Fitzgerald Report'), Queensland, Government Publisher, 1989.

<sup>68</sup> Morris, N., and Hawkins, G., *The Honest Politician's Guide to Crime Control*, Chicago, University of Chicago Press, 1970, at pp. 5-6.

<sup>69</sup> Dobinson and Poletti, *supra* note 40. Since the late 1980s and the implementation of the 'War on drugs' campaigns in Sydney, the number of people charged/convicted of drug-related crime increased dramatically. For example, between 1983-1989 the number of persons convicted in New South Wales Higher Criminal Courts increased by 200% (Australian Bureau of Statistics, *Higher Criminal Courts*, 1983, Table, 7, p. 6., New South Wales Bureau of Statistics and Research, *Higher Criminal Courts Statistics 1989*, Table 9, pp. 20-21).

<sup>70</sup> Goode, *supra* note 39, at pp. 181-2; Weatherburn, D., 'Crime and partial legalisation of heroin' (1992) 25(1) *Australian and New Zealand Journal of Criminology*, 11-26, at p. 18.

<sup>71</sup> Dobinson and Poletti, *supra* note 40.

congress ...'.<sup>72</sup> However, such a view is harmful to the position of women in society by reinforcing patriarchal dominance over them.

There is a tendency to ignore the benefits that partial legalisation, at least, of certain conduct may bring. For example, legalising IV drug use would provide heroin of adequate purity at a lower price which would remove the need for users to be in contact with criminals, to engage in prostitution to support the habit and they could continue to hold jobs.<sup>73</sup> The price would be so low that it would undercut the black market or at least decrease its size.

It is true that legalisation could have detrimental effects. For example, it could lead to more users; it may only prevent those activities which people want to stop; unsterile needle sharing might continue regardless of need; and, making heroin available to addicts may ignore the occasional user. Further, it is uncertain what it would cost to finance a scheme of administering heroin to dependent users. However, since implementation of decriminalisation in South Australia there has been no evidence of a flood of users.<sup>74</sup> It is a case of balancing the relative risks of continued criminalisation with partial legalisation.

Some of these factors were recognised as providing a solid basis for decriminalisation or legalisation of heroin use at a special Premiers Conference convened in April 1985 to determine future drug policies in Australia. Strategies developed as a result of that Conference focused on reducing the demand for drugs and controlling the drug supply.<sup>75</sup> The AIDS pandemic has led to renewed calls to decriminalise IV drug usage.<sup>76</sup> The 1989

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<sup>72</sup> Esselstyn, T. C., 'Prostitution in the United States' (1968) 376 *Annals of the American Academy of Political and Social Science*, 123-125, at p. 125.

<sup>73</sup> Baume, P., 'Overcoming Myths, Hypocrisy and Lies: Drug Law Reform in Australia', *New Doctor*, Autumn 1989:8-9. Marks, R., 'Prohibition or Regulation: An Economist's View of Australian Heroin Policy' (1990) 23 *Australian and New Zealand Journal of Criminology*, 65-87 at p. 83.

<sup>74</sup> Sarre, R., 'A Review of the South Australian Cannabis Expiation Notice System', presented at the Fifth Annual Conference of the Australian and New Zealand Society of Criminology, Sydney, July, 1989.

<sup>75</sup> Department of Health, *National Campaign Against Drug Abuse*, Canberra, Australian Government Publishing Service, 1985.

<sup>76</sup> Drew, L. H. R., and Taylor, V. K., *The second AIDS epidemic: spread via needle sharing to the general community: a review*, Canberra, Department of Community Services and Health, 1988, and see comment by Hawks, D., 'The proposal to make heroin available legally to intravenous drug abusers', *Med J Aust* 1988, 149:455-456. Wodak, A., 'Heroin Legalisation: To

Cleeland Report of the Parliamentary Joint Committee on the National Crime Authority put a case for a regulated supply scheme.<sup>77</sup> In addition, the Commonwealth Government has urged State Governments to repeal legislation criminalising possession of hypodermic syringes so as to facilitate the smooth operation of the needle-exchange programmes that have been set up in each State and Territory of Australia.<sup>78</sup> However, the Commonwealth government did not advocate decriminalising or legalising IV drug usage.<sup>79</sup> In the 1990s the issue is still being debated in both academic<sup>80</sup> and political circles.<sup>81</sup>

### (iii) The Limits of Legislation and the Practical Problems of Enforcement

One of the reasons for the failure of the criminal law to successfully enforce morality, shape public opinion, and maintain the smooth order of society is that legislation is often seen incorrectly as the cure for all social and moral

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be or not to Be?' *New Doctor*, Autumn, 1989:4-7. There have been many newspaper articles on this point: 'Legalise Heroin to Beat AIDS', *Sunday Telegraph*, June 18 1989, p. 3. There have also been numerous challenges to these calls indicating that even the experts are divided: 'Warning on decriminalisation of heroin', *The Age*, September 9 1989 and ' "Legalise heroin" call challenged', *The Mercury*, April 18 1989.

<sup>77</sup> Parliamentary Joint Committee on the National Crime Authority, *Drugs, Crime and Society*, (Cleeland Report), Canberra, Australian Government Publishing Service, 1989 at pp. 112-113.

<sup>78</sup> Commonwealth of Australia, *National HIV/AIDS Strategy: A policy information paper*, Canberra, Australian Government Publishing Service, 1989, at para. 5.7.13. The *HIV/AIDS Preventative Measures Act* (1992) (Tas.) endorsed the establishment of a needle-exchange scheme in Tasmania.

<sup>79</sup> 'Legalise Heroin to Beat AIDS', *Sunday Telegraph*, June 18 1989, p. 3. Don Dunstan, former Premier of South Australia and Alex Wodak, Director of the Alcohol and Drug Services at St Vincents Hospital, Sydney, are both reported as concurring in this view. See 'Legal heroin needed to fight disease, says Dunstan', *The Age*, August 18 1989 and 'Legalise heroin, says expert', *The Mercury*, March 16 1989.

<sup>80</sup> Reflected in the debate between Weatherburn, *supra* note 70, who concludes that there is no case to be made to justify a change in the current heroin policy, and Mugford, S., 'Crime and the partial legalisation of heroin: Comments and Caveats' (1992) 25(1) *Australian and New Zealand Journal of Criminology*, 27-40, who believes that 'current laws fail to grasp the social phenomenon of drug use correctly and hence [are] incapable of doing the job properly' (p. 37).

<sup>81</sup> The ongoing political debate about a variety of drugs including tobacco, alcohol and narcotics is reflected upon by Baume, P., 'Alcohol and politics', *Med J Aust*, 1991, 154:840-841 and in Carney, T., *The Unwinnable War Against Drugs - the Politics of Decriminalisation*, Melbourne, Pluto, 1991. It appears that in the 1990s in Australia the focus has shifted to developing supply-reduction schemes (Wardlaw, G., 'Overview of national drug control strategies', in *Comparative analysis of illicit drug strategies*, Monograph Series No. 18, National Campaign Against Drug Abuse, Canberra, Australian Government Publishing Service, 1992, at p. 5).

evils. As Morris and Hawkins state, legislation relating to drug use and sexual behaviour 'is based on an exaggerated conception of the capacity of the criminal law to influence men'.<sup>82</sup> Indeed, the failure of the criminal law to eradicate victimless crimes provides some support for the argument that the law experiences difficulties in controlling some social and moral problems. The unwillingness of people to face the fact that forces in society shape the criminal and their devotion to the idea that criminal activity can be reduced by repressive laws is at the heart of the problem.

Sumner is more emphatic that legislation cannot make mores. He believes that to be strong and effective legislation must be consistent with the mores of a society or the group affected but that it has little or no independent influence on behaviour.<sup>83</sup> Similarly Cranston, while recognising that there is no body of knowledge on how effective legislation is in influencing behaviour, believes that legislation is an insignificant instrument of control when compared with other social forces such as peer-group pressure.<sup>84</sup>

Aubert points out, though, that continued violations of laws do not indicate that legislation cannot change behaviour.<sup>85</sup> This is because action is related to knowledge; if an individual does not know of the law then it is doubtful his or her behaviour will change. To be effective the terms of a law must be precise.<sup>86</sup> The person or group to whom the legislation is addressed must know of it and the circumstances of its non-compliance. Broad statutory criminal standards are publicly complied with if they 'correspond with societal values and if they are precise and well known so that individuals can bring their behaviour into line without much official guidance.'<sup>87</sup>

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<sup>82</sup> Morris and Hawkins, *supra* note 68, at p. 2.

<sup>83</sup> Sumner, W. G., *Folkways: A study of the sociological importance of usages, manners, customs, mores and morals*, New York, New American Library, 1906, at p. 77.

<sup>84</sup> Cranston, R., 'Reform Through Legislation: The Dimension of Legislative Technique', in Tomasic, *supra* note 46, 88-106, at p. 89.

<sup>85</sup> Aubert, V., (ed), *Sociology of Law*, Harmondsworth, Penguin, 1969, 116-126 at p. 117.

<sup>86</sup> Hardesty, D. C., 'A Case Study of Legislative Implementation: The Federal Coal Mine and Safety Act of 1969' (1972) 10 *Harvard Journal of Legislation*, 99 at pp. 124-5.

<sup>87</sup> Cranston, R., in Tomasic, *supra* note 46, at p. 93.

Socialisation has an important role to play in the success of proscriptions. Individuals belong not only to society but also to individual groups. The norms of the group may lead people to commit crime. Minority cultures often commit crimes to outrage the dominant culture.<sup>88</sup> Some criminal laws may have been formulated for the groups that possessed the ability to dictate public policy, for example, US drug legislation (the development of the *Harrison Narcotic Act* (1914)<sup>89</sup>), but some were probably created for the benefit of the larger community, for example, vagrancy legislation.<sup>90</sup> Few people would take issue with those laws, largely because they have been socialised to respect or fear the law and legal institutions. Alternatively, people may commit crime out of dire need and until that need is satisfied by behaviour that is legal, they will continue to re-offend.

Legislation, rather than having the desired effect, may cause unanticipated and undesired results. For example, initial studies of the efficacy of drink driving legislation have found either that it has little deterrent effect<sup>91</sup> or that it is inconclusive whether the deterrent effect is merely temporary or permanent.<sup>92</sup> In the United States legislation and policies designed to control drug use have from their inception been a contributing factor in worsening the drug problem. As Goode states '... punitive approaches have been an almost unrelieved failure'.<sup>93</sup> The Australian Parliamentary Joint Committee on the

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<sup>88</sup> Pryce, K., *Endless Pressure*, Harmondsworth, Penguin, 1979.

<sup>89</sup> Duster, *supra* note 51, at p. 23.

<sup>90</sup> Hartjen, C. A., Hartjen, C. A., *Crime and Criminalisation*, 2nd ed, New York, Holt, Rinehart and Winston/Praeger, 1974, 31-35 and 49.

<sup>91</sup> Ross, H. L., 'The Scandinavian Myth: The Effectiveness of Drinking-and-Driving legislation in Sweden and Norway' (1975) 4(2) *Journal of Legal Studies*, 285-310. A concern voiced by the Australian Law Reform Commission in their report, *Alcohol, Drugs and Driving*, Canberra, Australian Government Publishing Service, Report No. 4, 1976, para. 258.

<sup>92</sup> Reconviiction studies do not support the fact that people with prior drinkdriving offences are more sensitive to the threat of sanction (Homel, R., 'Penalties and the drink driver: A study of one thousand offenders,' (1981) 14 *Australian and New Zealand Journal of Criminology*, 225-241). This view has been supported in Canada by follow up studies by Donelson, A. C., *Impaired Driving Report No. 4. Alcohol and Road Accidents in Canada: Issues Related to Future Strategies and Priorities*, Ottawa, Department of Justice, 1985 who concluded that low based, punitive measures cannot alone produce large, sustained reductions in the magnitude of the problem. He reaffirmed his conclusion in 1989 in *The Alcohol Crash Problem and its Persistence: The Need to Deal Effectively with the Hard Core of Drinking Drivers*, Ottawa, The Traffic Injury Research Foundation of Canada, 1989.

<sup>93</sup> Goode, *supra* note 39, at p. 179.

National Crime Authority has accepted that the policy of prohibition of drug use currently employed in Australia is not successful.<sup>94</sup>

There are also significant problems of enforcement for offences involving sexual activity and drug use. The legislature deals with crimes in advance of commission by the threat of condemnation and punishment to be imposed by other agencies. The very fact that these other agencies are involved may set limits on the ability of the legislature to accomplish what it sets out to achieve. Many sex crimes suffer from this practical difficulty. Often the conduct regarded as criminal on the statute book is committed in private, making police surveillance an invasion of privacy. Alternatively, the police may choose not to prosecute the conduct because of problems of proof.

In Tasmania, for example, the prosecution of victimless crime such as homosexual activity has been negligible. Between 1969 and 1993 only 115 persons have been convicted of crimes relating to homosexual conduct under sections 122 and 123 of the *Criminal Code* (Tas.).<sup>95</sup> The majority of those convicted involved non-consensual conduct, with only 2 persons charged with consensual homosexual conduct during that period. As most of the conduct prosecuted was non-consensual it was brought to the attention of the police by way of complaint, rather than through their detection. In one of the consensual cases Cosgrove J held that he did not believe the behaviour engaged in created any public mischief: 'it was a private affair between consenting adults.'<sup>96</sup> A 1988 Queensland District Court decision to discharge two males charged with sodomy and gross indecency under sections 208 and 211 of the *Criminal Code* indicates the courts' unwillingness to prosecute persons for the purpose of enforcing

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<sup>94</sup> *Drugs, Crime and Society*, *supra* note 77, at pp. 122-123. Similarly, Wodak, *supra* note 76, at p. 7), Leader-Elliott, I., ('Prohibition Against Heroin Use: Can They Be Justified?' (1987) 19 *Australian and New Zealand Journal of Criminology*, 225); Mugford, *supra* note 80, at p. 27 remark that existing drug policies in Australia have not been effective and are unsustainable. But, more recently Weatherburn, has asserted that the prohibition has not been shown to be ineffective (*supra* note 70, at p. 1).

<sup>95</sup> Calculated from research conducted of files supplied from the Department of Public Prosecutions, Justice Department, Tasmania in 1991 and updated in July 1994. Tasmania was selected as the sole jurisdiction of study because homosexual activity between consenting adults in private is a crime.

<sup>96</sup> *R v Garth*, unreported judgment of the Supreme Court of Tasmania, March 13th 1980 per Cosgrove J.

<sup>97</sup> Both examples are significant given that they came from States where homosexual activity has been (Qld) and still is (Tas.), illegal.

#### (iv) Limited Use of Criminal Law for Educational Purposes

If there is a difficulty in determining a common morality in a pluralist society, it must necessarily follow that attempting to use the criminal law as an educator of common morality must be problematic.

In fact, it would appear that the law has a limited ability to educate. Empirical studies support the argument that the criminal law has little educative value. Experiments have shown that people's judgements on at least some moral issues are influenced by what they are told is the majority view. <sup>98</sup> An early attempt to measure this phenomenon was undertaken by Walker and Argyle who surveyed attitudes to suicide after it was decriminalised. They found that there was no tendency for students who knew the law had been repealed to take a less strict moral view than those who did not know. <sup>99</sup> They concluded that at least in relation to suicide, that it was not possible to influence the moral opinions of students on the basis that a given action was prohibited by the criminal law. In practice, there are very few recognised successes of the criminal law operating to educate the public in crimes other than victimless crimes with the most often quoted failure being the United States prohibition laws. <sup>100</sup>

In relation to AIDS, Oppenheimer reflects on the strength of public opinion and the difficulty the law has in overriding those opinions once formed. He refers to the tendency of the Centre for Disease Control in the United States in the early days of the pandemic to base AIDS transmission on a 'promiscuous' lifestyle hypothesis. Such a hypothesis indirectly implied a moral judgement, one

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<sup>97</sup> In fact the court stated: 'the activities of two consenting adult males in the privacy of their own home is no outrage to public decency' (Lane, B., 'Harassment of homosexuals in Queensland, Private lives, public "crimes"' (1988) 132(4) *Legal Service Bulletin*, 54-157.

<sup>98</sup> Walker, N., and Argyle, M., citing Dasheill in 'Does the Law Affect Moral Judgments?' (1964) 4 *British Journal of Criminology*, 571-581.

<sup>99</sup> *Ibid*, at pp. 577-579.

<sup>100</sup> Friedmann, *supra* note 23, at p. 22 and see also Hartjen, *supra* note 90 citing Sutherland at p. 42.



that the community at large picked up and adopted in their search for scapegoats.<sup>101</sup> The media, particularly in the United States, also tended to back this view, which in turn led to widespread reactions of distrust of and discrimination towards certain groups in society.<sup>102</sup>

There is no doubt that the law does not respond rapidly to changes in the public opinion, especially with respect to moral issues. Stephen recognised the need for the law to be in line with public opinion when he argued that 'You cannot punish anything which public opinion, as expressed in the common practice of society, does not strenuously and unequivocally condemn.'<sup>103</sup> Certainly eighteenth century England relied heavily on public opinion for its practice. Hay describes how the rulers of eighteenth century England spent much time reading public opinion, the gentry aware that their security of position depended on belief in the justice of their rule. 'Punishment at times had to be waived or mitigated to meet popular ideas of justice ...'.<sup>104</sup>

Friedmann endorses Stephen's position by arguing that in a democracy the interplay between social opinion and the law activities of the State is more obvious, being expressed through representatives in the legislative assembly, media and associations.<sup>105</sup> Like Stephen, Friedmann argues that it is not possible to impose a law on an utterly hostile community.<sup>106</sup> Group interests may initiate and pursue a legal change in the face of the indifference of both government and public opinion but for it to work there must be a minimum of acceptance by the public.

Ideally public opinion must necessarily be ahead of legislative action. The government of the day would be unlikely to want Parliament to pass

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<sup>101</sup> Oppenheimer, G. M., 'In the eye of the Storm', in Fee and Fox, *supra* note 38, 267-300 at p. 279.

<sup>102</sup> See Altman, D., *AIDS in the Mind of America*, New York, Anchor Press/Double Day, 1986 in chapter 2: 'AIDS and the Media', at p. 16-21 where he makes reference to some sensational headlines.

<sup>103</sup> White, R. J., (ed), Stephen, J. F., *Liberty, Equality and Fraternity*, Cambridge, Cambridge University Press, 1967, at p. 159.

<sup>104</sup> Hay, D., *Albion's Fatal Tree: Crime and Society in Eighteenth Century England*, New York, Pantheon, 1975, at p. 51.

<sup>105</sup> Friedmann, *supra* note 23, at p. 24.

<sup>106</sup> *Ibid*, at p. 22.

laws which a majority of electors considered obnoxious. Politicians will endeavour to secure a political future by enacting legislation which is compatible with both public and professional feeling. However, there is always the possibility that if the law was to change to reflect public opinion it might lead to the enactment of harsh and repressive policies. The Western Australian Parliament exhibited this tendency in the passage of the 1992 juvenile justice legislation,<sup>107</sup> which was enacted in response to the despair of many members of the community at the perceived increase in the level of offences being committed by juveniles. The wisdom of the enactment has been debated.<sup>108</sup> It is significant that it contains a 'sunset-clause' confirming the fact that the legislature is 'testing the waters' with respect to public opinion with this particular piece of legislation.

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Practically speaking there are two distinct reasons why the law is not ahead of public opinion. First, those who make legislative decisions are unable to foresee the future. This is complicated by the fact that the changes in society are both rapid and unpredictable and it is not possible to determine beforehand what legal situations and problems may arise. Second, it is difficult to predict the future public and professional feeling which will accompany future circumstances; 'basic community views change from era to era'.<sup>110</sup>

If that is so then perhaps it is questionable that legislation has an educative quality. It is argued above that changing attitudes led to the amendment of legislation covering victimless crime. In the same manner, legislation in the last fifty years has rarely been enacted to prevent a social, moral or ethical problem. Legislation is usually enacted in the wake of an event. For example, the thalidomide tragedy led to amendments to the *Federal Food and Drugs Act* in the US and the enactment of the *Therapeutic Goods Act* (1966)(Cth) in Australia. Prior to this date, there had been no legislative basis in

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<sup>107</sup> *Crime (Serious and Repeat Offenders) Sentencing Act* (1992)(W.A.).

<sup>108</sup> Wilkie, M., 'WA's Draconian New Juvenile Offender Sentencing Laws' (1992) 2(55)*Aboriginal Law Bulletin*, 1992, 15-17.

<sup>109</sup> In addition, s. 13 states that the effectiveness and operation of the Act will be reviewed every three months.

<sup>110</sup> Derham, Maher and Waller, *Introduction to Law*, 5th ed, Sydney, Law Book Company, 1985, at p. 207.

Australia for the safety of marketed products to be monitored. Even with respect to AIDS, legislation generally has been implemented in the wake of the pandemic, for example, legislation limiting the liability for agencies providing contaminated blood in circumstances where the provision of such blood was without negligence.<sup>111</sup>

Earlier in this chapter, figures were provided from the Morgan Gallop Poll on homosexual conduct. The Poll indicated that 74% of the persons polled in Western Australia in 1989 supported decriminalisation. It is significant that in March 1990 the West Australian legislature decriminalised homosexual activities between consenting adults (over twenty-one years) in private.<sup>112</sup> This legislation reflects the dependency of lawmakers on public opinion. It may also reveal that governments are influenced by legislative activities in the other jurisdictions of a federation.

However, governments will not always act even in the face of strong local lobby groups. The slow progress of gay law reform in Tasmania is an example. In 1978 the Tasmanian Law Reform Commission report on victimless crime suggested that homosexual acts between consenting adults no longer be a crime.<sup>113</sup> The matter of decriminalisation was left in abeyance, but resurfaced in that State in 1987 with the advent of the AIDS epidemic. At that time the Tasmanian Parliament refused to repeal existing proscriptions against homosexual conduct despite the intensity of gay law reform movements in the State.<sup>114</sup> Then the Commonwealth *National HIV/AIDS Strategy* in 1989 urged States in Australia that still penalise homosexual conduct between consenting adults to consider repealing those provisions.<sup>115</sup> In an action that might be

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<sup>111</sup> s. 21DA *Human Tissue (Amendment) Act* (1987)(N.S.W.); *Health (Blood Donations) Act* (1985)(Vic.); *Blood Contaminants Act* (1985)(S.A.); *Blood Donation (Limitation of Liability) Act* (1985)(W.A.); *Blood Donation (Limitation of Liability) Amendment Act* (1987)(W.A.); *Blood Transfusion (Limitation of Liability Act)* (1986)Tas.; *Notifiable Diseases Act* (1985)(N.T.); *Blood Donation (Acquired Immune Deficiency Syndrome) Ordinance* (1985)(A.C.T.), *Blood Donation (AIDS Amendment) Act* (1986)(A.C.T.)

<sup>112</sup> Through the *Law Reform (Decriminalisation of Sodomy) Act* (1989).

<sup>113</sup> *supra* note 35, at para. 6.19.

<sup>114</sup> See 'Male homosexuality bid vetoed by MLC's', *The Mercury*, June 5 1987.

<sup>115</sup> *National HIV/AIDS Strategy*, *supra* note 78, at para. 5.7.11-5.7.12. See also, 'Gay law change in AIDS fight', *The Mercury*, October 10 1989, p. 5, which suggested that although legislation to decriminalise was being considered by the Tasmanian government '... as part of a package to fight AIDS', it would be unlikely to be introduced into Parliament in 1989.

regarded as one where a State government refused to submit to the will of a Federally backed policy, the *AIDS Preventative Measures Bill* (1990) was not passed by the Tasmanian Legislative Assembly.<sup>116</sup> This Bill contained provisions which would have decriminalised some homosexual practices and also legalised the setting up of a needle-exchange in that State. In 1993 the Bill was passed in an amended form which did not include homosexual law reform.<sup>117</sup>

In summary, for the reasons advanced in this section, the enforcement of morality is not a justification itself for the criminalisation of homosexuality, prostitution or drug use. It will now be considered whether the aim of preventing harm to others will provide the justification.

### THE PREVENTION OF HARM TO OTHERS THROUGH THE CRIMINAL LAW

Two schools of thought support the view that the overriding aim of the criminal law, is the prevention of harm to others. Utilitarians believe the prevention of harm should be the overriding aim. Liberals believe it is the only ground upon which the criminal law may intervene in the private lives of its citizens. This notion of harm is tied to the question of liberty of the person. The classical statement of this aim of the criminal law is found in the writings of Mill and more particularly in his essay *On Liberty* :

[T]he only purpose for which power can be rightly exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right.<sup>118</sup>

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<sup>116</sup> 'HIV/AIDS Bill to be amended' (1991) *National AIDS Bulletin*, August, p. 5.

<sup>117</sup> The *HIV/AIDS Preventative Measures Act* (1993) includes anti-discrimination clauses, provides the specifics of conducting HIV tests and provides legislative support for the compulsory testing of prisoners. The Tasmanian legislature's failure to decriminalise homosexual conduct has been held to be a breach of Australia's human rights obligations by the United Nations Human Rights Committee (*Toonen v Australia* CCPR/C/50/D/488/1992 reported in Anon, 'Tasmanian gay activist wins in the UN' (1994) 5/2 *HIV/AIDS Legal Link*, 1, 9).

<sup>118</sup> Mill, J. S., *On Liberty*, London, J.W. Parker & Son, 1859, 'Introductory' at p. 22.

For Mill the harm to others principle is the only valid reason for limiting liberty. Mill exempted consenting sexual conduct from legislative restraint because he believed it failed the test of immorality. In his view for an immoral act to be a criminal act it had to fall in the category of one which involved deliberately doing something that caused palpable harm.<sup>119</sup>

Mill believed that the criminal law should only address a very narrow range of anti-social behaviour. Writing in an era of excessive use of penal measures he believed that the criminal law had no jurisdiction over 'self-regarding' (or victim-less) offences such as abortion, homosexuality, and alcoholism, all which occurred in private and harmed only the individual involved in the activity. It is on this point that some inherent contradictions appear in Mill's theory. For example, he believed that prostitution should be criminalised.<sup>120</sup> Yet, under his own rules prostitution would fall within the category of a 'self-regarding' offence.

The difficulty with Mill's thesis is that in a complex society the sort of liberty that Mill referred to is unrealistic. There are social costs associated with the free pursuit of interests. For example, those who smoke and drink may affect other people in two ways. First, the smoker may damage the health of the non-smoker by exposing him or her to passive smoking. Second, those who drink and then drive may injure others by involving them in a car accident which in addition may lead to an increase in insurance premiums for the whole population.

Notwithstanding the criticisms that can be made of Mill in the 1990s, the Wolfenden Committee in the 1950s also came to a similar general conclusion.<sup>121</sup> According to the Committee, the aim of the criminal law is to

... preserve public "order and decency" to protect the citizen from what is "offensive or injurious", and to provide sufficient safeguards against exploitation and corruption of others,

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<sup>119</sup> Mill, J. S., *Utilitarianism, Liberty and Representative Government*, Dent & Co, 1910, at p.134-135.

<sup>120</sup> He believed that soliciting caused 'offence' to others whereas prostitution in private harmed no-one. The only reason offered for this view appears in his commentary on slavery; that any contract to be a slave even if voluntary would be null and void 'because [a person] abdicates his liberty' (*supra* note 118 p.125). Apart from this fact there seems no reason in principle why prostitution should have been considered as more 'harm producing' than either homosexuality or adultery.

<sup>121</sup> and in fact retained prohibitions against prostitution-related activities.

particularly those who are specially vulnerable because they are young, weak in body or mind, inexperienced, or in a state of special, physical, official or economic dependence ... <sup>122</sup>

It was the members' belief that there is a sphere of morality which is best left to the individual conscience. It was not the role of the criminal law to 'intervene in the private lives of citizens, or to seek to enforce any particular pattern of behaviour'. <sup>123</sup>

While Hart in principle agreed with Devlin that homosexuality, prostitution, fornication and adultery were substantially immoral he argued that they should be exempt from legislative restraint. For Hart, the right to undisturbed performance of private consenting acts is more important than the immorality of the act.

Recognition of individual liberty as a value involves, as a minimum, acceptance of the principle that the individual may do what he wants, even if others are distressed when they learn what it is that he does - unless of course, there are other good grounds for forbidding it. <sup>124</sup>

The last few lines of this quote would seem to suggest that Hart would agree with Mill that the only right to interference in the sphere of private morality is if harm occurs. However, Hart indicated that he did not agree with Mill in totality. He thought

there may be grounds for justifying legal coercion of the individual other than the prevention of harm to others. [<sup>125</sup>] But on the narrower issue relevant to the enforcement of morality [that the criminal law can only be used to enforce morality where harm is likely to flow to others from the activity], Mill seems to me to be right. <sup>126</sup>

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<sup>122</sup> Wolfenden Committee, *supra* note 14, at para. 13.

<sup>123</sup> *Ibid*, at para. 14. As Duster, T. S. notes 'An important contemporary shibboleth is "you can't legislate morality"' (*supra* note 51, at p. 3).

<sup>124</sup> Hart, *supra* note 11, at p. 47.

<sup>125</sup> Here Hart is making reference to the fact he favours legal paternalism; that a man's good may justify interference.

<sup>126</sup> Hart, *supra* note 11, at p.5. It is also important to note that Hart did not agree with Mill on his views as to the role paternalism played in the shaping of criminal offences. In fact his

In the 1970s Morris and Hawkins argued that 'the prime function of the criminal law is to protect our persons and our property.'<sup>127</sup> They proclaimed that the criminal law must 'strip off the moralistic excrescences' leaving the criminal justice system to concentrate on the essentials.<sup>128</sup> They commented,

... [w]hen the criminal law invades the spheres of private morality and social welfare, it exceeds its proper limits at the cost of neglecting its primary tasks ... For the criminal law at least, man has an inalienable right to go to hell in his own fashion, provided he does not directly injure the person or property of another on the way.<sup>129</sup>

It would appear that all these writers recognise that the State had by the implementation of victimless crimes sought to enforce a common morality through the criminal law. They argued that this was an unnecessary intrusion into the private lives of citizens except in cases where immorality would harm other members of society.

Advancing the harm principle as the overriding aim of the criminal law does leave many questions unanswered such as what is to count as harm? How is harm to be proved? The term harm itself is vague. A person may suffer harm without suffering injury. For example, a victim of defamation suffers harm to his or her reputation but may not suffer physical or economic injury. Of course injury itself is problematic. One may be injured economically by a fall in the stock market but not injured physically.

Harm is usually used where some act of a person is involved. The intention of the actor is important to the concept of harm. Not all intentional infliction of pain is harmful. Equally, some infliction of pain is harmful but not intentional. It also depends upon whether one is focusing on the actor or the victim. If a victim is burglarised without his or her knowledge he or she is harmed but not in the sense of hurt or pain.

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comments attack both Mill and Devlin on this point. About Mill he comments, 'Mills protest against paternalism ... may now appear to us fantastic' (*supra* note 118, at p. 32) and at p. 31, he criticises Devlin's view that prohibitions were there to enforce morality, not to protect that agent from harm in a paternalistic fashion.

<sup>127</sup> Morris and Hawkins, *supra* note 82, at p. 2.

<sup>128</sup> *Ibid*, at p. 2.

<sup>129</sup> *Ibid*, at p. 2.

Further, not all harm is treated as criminal. Feinberg argues that the only concept of harm that can be rightly considered by the criminal law is that which involves the 'setting back of an interest'.<sup>130</sup> A person harms another in this sense by invading and thwarting or setting back his or her interest. For example, if money is stolen from an individual he or she has less money and so his or her interests are set back in that sense. Feinberg also believes that the sense of harm employed in the harm principle 'represent setbacks to interests that are wrongs and wrongs that are setbacks to interests.'<sup>131</sup>

Hence, Feinberg argues that not every act that causes harm to others can rightly be prohibited but only those that cause avoidable and serious harm. Encompassed within his theory, is the proportionality principle: if the benefit outweighs the harm the conduct involved should not be characterised as harmful. For example, imprisonment is clearly a harm but is seen as justified according to sentencing principles for particular offenders. Feinberg sees a need to grade harms in terms of their seriousness. He identifies three categories of harm, namely, serious, intermediate and lesser harms. This grading system, however, is highly abstract. Feinberg does not indicate how certain harms are to be classified.

Adding to the complexity is the individual's view of harm. The individuals view may be directly related to how successful a proscription is in controlling behaviour. For example, some people may believe that it is harmful to engage in smoking marihuana, while others may not. Those who believe it is not harmful may not be persuaded by proscriptions to avoid smoking the drug. If a community consensus were to be obtained as to what was harmful before a certain activity were prohibited it is doubtful whether a conclusive common ground could be found.

Harm may also be direct or indirect. The diversion of funds from public taxes to the rehabilitation of drug addicts is not as readily identifiable as a harm to the public interest. However, there is no reason why economic harm should not be considered within the realm of harms which may justify criminal prohibition. Stamping out direct harm to an individual's or the community's health through criminalisation of drug use may reduce or eradicate indirect

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<sup>130</sup> Feinberg, *supra* note 13, at pp. 33-36.

<sup>131</sup> *Ibid*, at p. 36.



harm to the public interest through depletion of public monies spent on rehabilitation.<sup>132</sup> This is of course based on the assumption that the proscriptions would be followed and the history of drug use world-wide reveals that prohibitions have not been followed. Irrespective of this fact, the decision as to whether or not conduct should be labelled as criminal should take into account direct and indirect harms to the public interest and whether the eradication of one harm would likely eradicate another. It is possible though that the categorisation of 'direct' or 'indirect' would prove just as problematic as Feinberg's 'serious, intermediate and lesser harms' dichotomy.

### LEGAL PATERNALISM

Those who support the view that legal paternalism is the overriding aim of the criminal law believe that the State has a right to intervene to protect the agent from harm. Paternalists would argue that restraints must be imposed in order to protect the individual from moral, physical and/or psychological harm. Taken to its extreme, paternalism could be said to apply in a totalitarian society where governments adopt social and cultural policies which are objectionable to a majority of citizens of a country.

Paternalists differ from fundamentalists such as Devlin or Stephen because they are more concerned with harm to self than harm to society or others.<sup>133</sup> Paternalists also differ from utilitarians or liberals because they believe intervention is always necessary to prevent harm to the agent be it moral or physical harm. Mill as a utilitarian quite clearly advocated that interference for the good of the agent was not a sufficient ground for interference.<sup>134</sup> His view was that any State invasion in self-regarding offences is a wrong because it is a violation of the privacy of the self.

However, as utilitarians, Hart and Feinberg acknowledge that

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<sup>132</sup> Although it is recognised that it is more than likely that rehabilitation will be needed in tandem with a policy of criminalisation to eradicate drug use.

<sup>133</sup> Feinberg, J., *Harm to Self*, Vol. 3, Oxford, Oxford University Press, 1984, chapter 17, 3-26. Stephen has been described as a 'Victorian utilitarian' by Harris, *supra* note 32, at p. 117.

<sup>134</sup> Mill, *supra* note 118, at p. 15.

paternalism underlies much of the criminal law.<sup>135</sup> In liberal democratic countries this has always been accepted as encompassed within the *parens patriae* power of the State. This is in accord with the original aim of the criminal law which was to protect a person for the good of society. This is clearly reflected in the laws relating to mayhem or maiming. For example, duelling and fighting were lawful but where a maim occurred they were rendered unlawful because the King was deprived of the services of an able-bodied man for the defence of the realm.<sup>136</sup> It might be argued that during the nineteenth and twentieth centuries we have moved to a more restrictive role for the State as illustrated by the decriminalisation movement for victimless crimes. However, there are more crimes on the statute books in the 1990s than there were in the 1890s.

Paternalism restricts the occasions for interference to cases where there are harmful consequences to the agent or where the agent's decision is suspect. At least one commentator has usefully divided the paternalistic response into 'hard' and 'soft'.<sup>137</sup> The soft response would involve intervention only where the agent's apparent choice was not truly his, that is to say, it was not voluntary. The hard response defines the situation of intervention where the apparent choice was voluntary but the State decided to intervene anyway. There is no doubt that the criminal law displays instances of at least 'soft' paternalism. For example, the law as to when consent may or may not be a defence is based on notions of paternalism; that an individual cannot adequately look after himself or herself. Where the defence is raised in sexual assault cases the State will intervene and deny the defence if, for example, the consent is not voluntary because it was obtained by fraud, force or threats. Few would take issue with this form of protection. However, instances of 'hard' paternalism are more controversial. One example is the notion that an individual cannot consent to death. The current stance towards criminalising euthanasia is an example of 'hard' paternalism. The argument often advanced against legalising euthanasia is that the dying patient may not know his or her mind and

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<sup>135</sup> Hart, *supra* note 11, at p. 32; and Feinberg, *supra* note 13, at p. 26-27. These two philosophers could be said to reject both the view that protection of the person from himself is always justified and the view that it is never justified.

<sup>136</sup> *Hawkins Pleas of the Crown*, Vol. 1, 8th ed, 1824, chapter 15.

<sup>137</sup> Feinberg, *supra* note 61, at p. 80.

that he or she may have a transitory desire to die dependent on mood cycles. <sup>138</sup> 'Hard' paternalism also appears as the driving force behind drug legislation which sees the administration or use of intravenous drugs illegal in all States and Territories of Australia (except Queensland). <sup>139</sup> Consent is irrelevant to such an activity due to the underlying rationale of preventing harm to the agent. It might also be argued that the limitations on consent in this example are intertwined with the notion of protecting the public order and good morals. This is manifested in the common law prohibiting persons from consenting to acts that are contrary to public policy. <sup>140</sup> Considering these examples, it is arguable that paternalists would support the enforcement of a common morality through the criminal law in cases where it was necessary to protect the agent from harm. On those occasions, the State has a right and a duty to maintain victimless crimes.

Relying on paternalism *per se* as a justification for criminalisation of certain behaviour is problematic for the following reason. It is essentially anti-democratic. One may question what expertise the person has who makes the decision as to what is or is not harmful to the agent. For example, the effect of drug use on the individual is fraught with medical controversy. <sup>141</sup> The effects of some drugs are incontrovertible but others are plainly grey areas, for example, heroin as opposed to cannabis. Is such dubiously based paternalism acceptable? This is an important question if paternalistic notions lead to the criminalisation of some mood-altering substances and not others. For example, the use of marihuana is not fully legal as opposed to both tobacco and alcohol which have been shown to be harmful <sup>142</sup>, yet both are legal activities.

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<sup>138</sup> Gillett, G., 'AIDS: The Individual and Society', in *Legal Implications of AIDS*, Legal Research Foundation, Auckland, May 1989, 101-110 at p. 110-111.

<sup>139</sup> The provisions were outlined in footnote 1.

<sup>140</sup> Consent is covered in more detail in chapter three.

<sup>141</sup> See the official report of the National Commission on Marihuana and Drug Abuse, *Marihuana, A Signal of Misunderstanding (Shafer Report)*, New York, Signet, 1972 and Siegel, S., 'Alcohol and Opiate Dependence. Re-evaluation of the Victorian Perspective', in Cappell, H. D., Glaser, F. B., and Israel, V., *et al*, (eds), *Research Advances in Alcohol and Drug Problems*, Vol. 9, New York, Plenum Press, 1980, 279-314.

<sup>142</sup> In fact, in 1992, from a total of 26,355 drug-related deaths in Australia, opiates, barbiturates and other drugs caused 816 deaths compared to 6,547 alcohol-related and 18,965 tobacco-related deaths (National Drug Strategy, *Statistical Update*, Canberra, Department of Human Services and Health, 1994:3, Table 2, p. 2).

Criminalising drug use may have been motivated by paternalistic notions or by the desire to enforce morality, but it has not been successful. Like prostitution, money and need universally override morality in the area of drug abuse. In any event the rationality behind criminalising drug use is based on a possible misconception that drugs such as heroin and marihuana have been proven to be dangerous. Hence, it could be argued that such dubiously based paternalism has not been acceptable.

However, there appears to be general agreement among philosophers that paternalism is sometimes justified. In addition, it must be accepted that some of the paternalistic regulations are reasonable. This is probably because many have come to acknowledge the merits of the 'soft' as opposed to the 'hard' paternalistic response. If one were to give due weight to Mill's criticism that paternalism tends to be blind to the fact that each person is the best judge of his or her own interests, then the aim of lawmakers would be to prevent self-inflicted harms without compromising a persons' individuality. What results is a division between justified and unjustified paternalism and a difficult line needs to be drawn between the two. In the final analysis, it is likely that the only way an attempt can be made to resolve the conflict between individual freedom and social responsibility is to consider paternalism on a case-by-case basis.

### **3. APPLYING THE AIMS OF THE CRIMINAL LAW TO HIV TRANSMISSION**

The foregoing has indirectly established that history provides many examples of the fact that criminalisation of any form of social behaviour is tied to the politics of particular governments at certain periods. The continual reluctance of the Tasmanian Legislative Assembly to lift prohibitions against homosexual conduct in that State when it has been decriminalised in all the others is an example. Many health-related issues such as smoking, alcohol, drug abuse and transmission of disease have created problems of control for governments. For example, when dealing with drug use it has been questioned whether it is a medical, moral, social, public health or criminal problem. Is it a matter for legislation and enforcement? Hence drug use cannot be neatly categorised into any convenient paradigm or framework to explain the world.<sup>143</sup>

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<sup>143</sup> A term used by Kuhn, T. S., *Structure of Scientific Revolutions*, Chicago, University of Chicago Press, 1970.

In addition, paradigms change. The various paradigms of drug use have changed in Australia and throughout the world shifting between the medical and penal explanations. Paradigms can also co-exist. For example, for one person prevention of drug use may mean education programmes and for the government minister responsible for law enforcement, prevention may mean strengthening penal deterrence or announcing a legal war on drugs. This divergence of opinion is also present in arguments surrounding the criminalisation of HIV/AIDS. It may be that governments will elevate one aim of the criminal law over another in this area. It is therefore necessary to consider whether each of the aims of the criminal law outlined above would be served by the express criminalisation and prosecution <sup>144</sup> of HIV transmission.

First, however, it is necessary to clarify the three ways in which the criminal law could be used to criminalise the transmission of HIV. There is the indirect method by way of applying laws which criminalise sodomy, prostitution or drug use. Under such provisions it would not be necessary to prove that an accused was HIV-infected. The second method is more direct and would involve applying traditional offences to the transmission of HIV. The third method would involve the establishment of an HIV-specific offence. <sup>145</sup> Criminalisation by indirect means is discussed below.

### THE ENFORCEMENT OF MORALITY AND HIV TRANSMISSION

It has been stated in the introduction to this chapter that HIV/AIDS is more prevalent in those sub-groups of the population addressed in this chapter such as homosexuals, prostitutes and drug users. The lack of zeal in prosecuting the activities engaged in by these groups may be viewed by some as contributing to the spread of HIV through the heterosexual population. The fact that a number of homosexuals are also both bisexuals and IV drug users and

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<sup>144</sup> The present writer treats these terms as separate. Criminalisation refers to the labelling of an activity as criminal by its placement in the statute books or the extension of existing laws to cover a particular activity. Prosecution requires another active step taken by law enforcement agencies rather than the legislature in charging a person for the offence and then applying the trial process to him or her.

<sup>145</sup> The second method will be considered in chapter three and the issue of establishing an HIV-specific offence will be covered in chapter four, pp. 146-156.

many prostitutes also engage in IV drug use fuels the debate.<sup>146</sup> As these activities have for time immemorial carried moral overtones, the incidence of HIV infection within these groups<sup>147</sup> provides moral fundamentalists with more support for the proposition that the law should step in to curb the social excesses of these individuals in particular.

If the enforcement of morality is to be regarded as the overriding aim of the criminal law then it is likely that particular groups will be selected as sources of infection for prosecution under the guise of criminalising for transmission of HIV. As such status rather than conduct would be the major impetus behind selection and hence criminalisation. It is also likely that the problems of enforcement that were discussed in relation to other 'immoral' activities would be encountered<sup>148</sup> since the activities capable of transmitting the virus are often conducted in private and with apparent consent.<sup>149</sup> Stepping up prosecutions for prostitution and drug-related offences in an attempt to curb the spread of HIV would serve no purpose other than that which has already been achieved prior to the advent of HIV. In fact, with prostitution such a stance is unjustified given that there is no documented case of HIV being transmitted by a prostitute to a client in Australia.<sup>150</sup>

In fact, while prostitution and drug use continue to exist, self-regulation and education may be more effective in curbing the spread of HIV when it occurs during the course of those activities rather than legislative

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<sup>146</sup> See article Perkins, R., Lovejoy, F., Dean, M.J., Wade, A., 'AIDS preventative practices among female prostitutes in NSW and ACT' (1991) *National AIDS Bulletin*, September, 28-32. Here evidence is provided that there has been a decline in use of "heavy" drugs by prostitutes between 1985/6 and 1990 (p. 30-31). In 1991 it was thought that 90% of street workers (who in total comprise only 10% of the total female prostitute population) in Sydney were IV drug users (Philpot, C. R., Harcourt, C. L., and Edwards, J. M., 'A survey of female prostitutes at risk of HIV infection and other sexually transmitted diseases', *Genitour Med*, 1991, 67:354-388).

<sup>147</sup> The *National HIV/AIDS Strategy* (*supra* note 78) acknowledges that Australia has a low prevalence of HIV among the sex-industry. Among the reasons given are that there have been many representative organisations that have acted early to provide peer-based educational messages (at para. 4.2.19). See also studies in footnote 3 *supra*. It is significant that in Australia there is actually no documented case of HIV being transmitted by a prostitute (Donovan, B., 'Female sex workers: so far so good' (1990) 4 *National AIDS Bulletin*, 17).

<sup>148</sup> Leading to entrapment as a principal means of securing prosecutions (Lane, B, 'Harrassment of homosexuals in Queensland: Private Lives, public "crimes"' (1989) 13(4) *Legal Service Bulletin*, 154-157, at p. 156).

<sup>149</sup> This issue of informed consent is considered in chapter six, pp. 245-246.

<sup>150</sup> See Donovan, *supra* note 147.

prohibitions. The Commonwealth Government has recognised this in relation to prostitution since 1989 when they suggested that 'State governments review legislation, regulations and practices that impede HIV education and prevention programs among prostitutes and their clients.'<sup>151</sup> A 1991 report released by the Queensland Criminal Justice Commission argues that the reduction of restrictions on soliciting by prostitutes in New South Wales has had a direct impact on the success of HIV and other STD prevention programmes in that State.<sup>152</sup> Laws against prostitution are detrimental to the position of women in society. We should be empowering women and encouraging them to adopt more barrier methods rather than stigmatising them.

In relation to drug use, given that all Australian Governments have set up needle-exchanges and repealed provisions prohibiting the possession of hypodermic needles and syringes, it would be hypocritical for governments to either penalise transmission of HIV indirectly through needle sharing in the absence of evidence of fraudulent conduct as to the contents of the syringe, or increase penalties for heroin abuse. To do so would be a step backward from all the work that has been done trying to bring IV drug users 'up from underground'. It is imperative that the issue of HIV transmission is not obscured in the debate about the morality or otherwise of homosexual conduct, prostitution and drug use.

### PREVENTION OF HARM TO OTHERS AND HIV TRANSMISSION

There is no doubt that the harm principle enjoys a privileged status for it is rarely questioned whether or not the criminal law should prevent harm to others. The main problem that needs to be focused on is how the harm principle should be interpreted and applied to particular cases. The question that is often asked in deciding whether or not to criminalise certain conduct, is whether or not criminalisation will produce better consequences for society and for most people, than would the failure to act at all. The converse is also important, i.e. whether criminalisation will produce more harm. This is where a

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<sup>151</sup> at para. 4.2.22 of the *National HIV/AIDS Strategy* (*supra* note 78).

<sup>152</sup> Criminal Justice Commission, *Regulating Morality*, Criminal Justice Commission Research and Co-Ordination Division, Queensland, 1991. In New South Wales, the soliciting provision under section 19(1) of the *Summary Offences Act* (1988) refers to soliciting in a public place. The effect of the provision is to prevent soliciting in residential areas only.

number of arguments that were raised when considering the prevention of harm in the context of homosexual conduct, prostitution and drug use become applicable to the question of criminalising HIV transmission.

For example, it was suggested earlier in this chapter that it must be considered whether more harm will result from a given activity being regarded as illegal. Accordingly, if criminalising transmission of HIV resulted in many HIV-infected persons going 'underground', Bentham would probably have held that a greater harm had resulted to society and to the individual who would not be counselled and cared for and might infect a greater number of the population. It is reasonable to assume that many persons will not present for HIV testing, treatment or counselling if they fear prosecution. In fact, this point has been consistently made with respect to the criminalisation of HIV transmission<sup>153</sup> as it has by those in favour of decriminalising homosexual conduct,<sup>154</sup> prostitution and drug use. In regard to STDs, Saragin in 1974 noted that penalties imposed for failing to name partners suffering from infectious sexually transmitted diseases deterred diseased persons from co-operating with authorities.<sup>155</sup>

In order to consider the aspect of criminalising HIV transmission on the ground of preventing harm to others further, it is instructive to return to Mill's thesis. Mill stated that individuals should be free to do whatever they choose, so long as their chosen activities do not seriously and directly cause harm to others. He thought that individual liberty would be generally beneficial because each person is the best judge of his or her own interests. Mill himself might retract this if he could see the present day drug scene. Nevertheless, Mill's thesis in its underlying theme that every society should allow some scope for self abusive, reckless, or corrupting conduct, is right. Criminalisation must be

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<sup>153</sup> Millman, C., 'Sodomy Statutes and the Eighth Amendment' (1988) 267 *Columbia Journal of Law and Social Problems*, 304-360 at p. 305. Ballard, J., 'The Politics of AIDS', in Gardner, H., *The Politics of Health: The Australian Experience*, London, Churchill Livingstone, 1989, 349-375. This view is the underlying theme of the early article by Kirby, M. D., 'AIDS Legislation - Turning up the Heat?' (1986) 60 *Australian Law Journal*, 324-332.

<sup>154</sup> Indeed the Preamble to the *Criminal Code and Another Act Amendment Act* (1990)(Qld.) which decriminalised homosexual activity in that State indicates that the threat of HIV infection is at the heart of the move to decriminalise. Paragraph 5 of the Preamble reads: 'rational public health policy is undermined by criminal laws which make those who are at high risk of infection unwilling to disclose that they are members of a high risk group'.

<sup>155</sup> Saragin, E., in Blumberg, *supra* note 39, at p. 157 and see comments made to this effect by Leo Abse during his speech for the second reading debate on the *Sexual Offences (No. 2) Bill* in 1966, cited in Blom-Cooper and Drewry, *supra* note 54, at p. 110.



limited in a manner which does not restrict people's private enjoyment but recognises that others may be harmed.

A perceived harmful link does exist between these activities and HIV transmission by virtue of the fact that unsafe sexual conduct believed to be associated with homosexual and prostitution activities and unsafe needle sharing conduct associated with IV drug use, operate as some of the vehicles for transmitting HIV. As such, there is some merit in the argument that homosexual conduct, prostitution and drug use are harmful in an indirect sense because they are high-risk activities for transmission of the virus. This is the impetus behind arguments in favour of stepping up surveillance of these activities in order to curb HIV transmission.

Criminalising consensual <sup>156</sup> activities that take place in private on the basis that they are harmful requires a very broad definition of what is 'harmful'. If events are confined to and occur between willing partners in a private place and do not affect the function of the participants in society, then history shows that it serves no useful purpose for authority to criminalise them. By contrast, if events do intrude into the lives of other members of society, and as such are likely to affect the health and welfare of these members, then it is the duty of authority to proscribe such intrusion. HIV however it is transmitted is a death producing virus. It is this factor that separates the transmission of HIV as particular conduct worthy of criminalisation from homosexual conduct, prostitution and drug use. It is not then in Mill's sense, a 'self-regarding' or victim-less offence. <sup>157</sup>

However, criminalising the transmission of HIV by focusing on homosexuals, prostitutes and drug users would at best focus on criminalising the 'risk' only of harm to others. We need to decide if the causing of offence or the creation of risk is to count as harms? If the latter is to be the case the pool of potential offenders widens. This would lead to the creation of a crime that would be indirectly harmful to others whereas other crimes are directly harmful to

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<sup>156</sup> What constitutes consent or lack of it in relation to an HIV infected partner will be discussed in chapter three, 114-123.

<sup>157</sup> Although it does need to be reiterated that depending on one's perspective it might be possible to argue that prostitution and drug-use are not self-regarding where, for example, the drug user depletes the family income and renders his or her dependents homeless to satisfy his or her habit. It might be argued that a person who contracts HIV/AIDS through sexual contact or needle-sharing actively participates in the very action that harms him or her and as such, is not a victim.

others. This is not the only ground why HIV transmission should not be criminalised in this way, for the criminal law already prohibits a number of indirect offences under the name anticipatory or inchoate offences, for example, attempts and conspiracy. The rationale behind these offences is to prohibit conduct x because it increases the likelihood of harm y. In this respect having sexual intercourse with a prostitute or homosexual or sharing drugs could be rendered criminal because it increases the likelihood of harm y occurring (transmission of HIV). This is the same rationale for why drug use or possession is criminalised because it will often lead to burglaries. However, to justify this the causal connection between the two must be established together with a proven substantial risk of harm y occurring in a high percentage of cases. It is doubtful that this could be done in relation to prostitution given the fact that it is well-documented that prostitutes engage in oral sex (which is of little or no risk of transmission)<sup>158</sup> 75% of the time. Commentators have long stated that the criminal law should not proscribe trivial harms; the rule known as *de minimis non curat lex*. The criminal law should tread carefully here because the wide use of anticipatory offences results in an expansion of police power. This may ultimately result in an enlargement of the harm principle exponentially so that it will cover a broader range of conduct. By doing this the definition of harm is expanded to include those acts that 'threaten harm' as well. When this fact is combined with the tendency for law enforcement agencies to target specific sub-groups of the population who readily come to their notice, such as drug users, it suggests that such a course should not be adopted.

To criminalise all who facilitate HIV transmission without question would be to ignore the circumstances surrounding a particular transmission episode. For example, homosexuals engaging in anal intercourse and IV drug users sharing needles would be treated the same as, for example, the bandit or the HIV-infected rapist who either threatens to or injures V with an HIV contaminated syringe. The criminal law should seek to prohibit only those acts which involve the intentional or wilful and even reckless transmission of HIV through direct, uninformed and non-consensual activity, i.e. this is the only level of harm or the 'threat of harm' that should be brought within the criminal law.

The elevation of the harm principle as the overriding aim of the criminal law is threatened by a 1993 decision of the House of Lords which has

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<sup>158</sup> See chapter one and Decker, 'Prostitution as a Public Health Issue' in Burris, *supra* note 9, at p. 81.

implications for the status of legal paternalism and the enforcement of morality in the context of HIV/AIDS and will be covered below.

### LEGAL PATERNALISM AND HIV TRANSMISSION

In 1993 the House of Lords handed down a decision which is likely to be accepted in Australian common law jurisdictions at least. In *Brown*<sup>159</sup> the House of Lords by a 3:2 majority on appeal found the defendants guilty of assault occasioning bodily harm under section 47 of the *Offences Against the Person Act* (1861)(U.K) where they had practised sado-masochistic activities on consenting males. This was irrespective of the fact that the activities were carried out in private, the injuries were not permanent (although were more than merely transient or trifling) and that there were no complainants. The tenor of their Lordships judgement was to elevate either the enforcement of morality or legal paternalism or a combination of both over the prevention of harm as the aim of the criminal law. This was manifested under the guise that the public interest demanded that people should not be able to harm others or consent to being harmed in private for no good reason.<sup>160</sup> In reality their public interest argument translates into a public morality one.<sup>161</sup> In addition, if the majority decision in *Brown* is correct, a person can only give consent to bodily harm where it serves the public interest. Allowing the judiciary to determine issues on a case-by-case basis is unsatisfactory bringing uncertainty to the criminal law. The dissenting judges in this case were concerned about this very fact.<sup>162</sup> It is likely that if their Lordships were faced with a case where two parties had consented to activity high-risk for

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<sup>159</sup> [1992] 2 WLR 441 (CA), [1993] 2 WLR 556 (HL)

<sup>160</sup> This represented the decision of the Court of Appeal as expressed by Lord Lane CJ at p. 449. This principle derived from an earlier judgment of Lord Lane in *Attorney-General's Reference No. 6 of 1980* [1981] QB 715 was upheld on appeal to the House of Lords.

<sup>161</sup> For example, Lord Justice Templeman stated 'the question whether the defence of consent should be extended to the consequences of sado-masochistic encounters can only be decided by considerations of policy and public interest' (at p. 563). Lord Justice Jauncey seemed to be concerned with the dangerousness of the activity and the need to deter and prevent corruption of the young (at p. 574).

<sup>162</sup> Both Mustill LJ (at p. 600) and Slynn LJ (at p. 608) thought that it was for Parliament not the judiciary to decide if this behaviour was so extensive in society and undesirable that it should be brought within the criminal law.

transmission of HIV, they would rule consent inapplicable.<sup>163</sup> By the same token, where a person transmits a disease which does not seriously affect the health of another consent may be raised as a defence. It remains to be seen whether the decision in *Brown* will encourage law enforcement agencies to step up prosecutions against those perceived as engaging in high-risk behaviour such as homosexuals, prostitutes and drug users. It is too early to detect such a pattern in England and Wales.

The *Brown* case also reinforces the fact that liberal principle is often one of the considerations missing when paternalism is being debated. The debate is conducted in utilitarian terms. The missing consideration is whether people should have the right to do whatever they choose, even if the social consequences of such permissiveness are less than optimal. If we wish to be properly liberal we should resist all forms of social paternalism. However, self destructive harm cannot be separated from harm to the community.<sup>164</sup> Drug use with its resulting increase in property crime is one example. The effect that the incidence of HIV/AIDS has had on the economic, social and political structures of some developing countries is another.<sup>165</sup>

It could be said that saving a person from harming him or herself is less of a compelling interest for the State than saving them from harming each other. In fact, in the context of HIV, a policy of prosecution based on paternalism would not actually advance the welfare of the HIV-infected person because it may deter him or her from medical care to his or her detriment. Therefore, State intervention would not protect such persons from moral, physical and psychological harm. In addition, and of concern to both utilitarians

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<sup>163</sup> Especially since the issue of HIV came up as a material factor directly related to the dangerousness of the activities engaged in, in the judgments of Templeman LJ (at p. 565), Jauncey LJ (at p. 574) and Lowry LJ (at p. 583). This is in direct conflict with the case of *Clarence* ((1888) 22 QBD 23) which is covered in detail in chapter three. In *Clarence* some members of the court (Hawkins J, at p. 54 and Field J, at p. 58) were of the opinion that the risk of quite serious harm, including venereal disease, might be freely consented to, thereby making serious assault lawful. Later cases, such as *Donovan* [1934] 2 KB 498 and *Attorney-General's Reference (No. 6 of 1980)* [1981] QB 715 suggested this was outdated but did not clearly state what level of harm is legally permissible. Their Lordships in *Brown* were therefore faced with vague legal precedents when considering the case before them.

<sup>164</sup> This was in fact the gist of Stephen's criticism of Mill's thesis for liberty. It is in fact a weakness of Mill's thesis because it can be argued that a harm is a harm whatever its cause. Stephen believed that no clear line could be drawn between acts which harmed others and acts which harmed only oneself.

<sup>165</sup> Cross, S., and Whiteside, A., (eds) *Facing up to AIDS: Socio-Economic Impact on Southern Africa*, London, Macmillan, 1993.

and liberals, criminalisation on the grounds of paternalism may, in fact, impose a greater harm on a third party.

#### 4. CONCLUSION

The focus in this chapter has been on considering whether the debated aims of the criminal law - the enforcement of morality, prevention of harm to others and paternalism individually or collectively justify the criminalisation of HIV transmission either directly or indirectly. The discussion has necessarily led to the examination of the liberal and conservative legal philosophies that differ radically in locating the point at which individual liberties should yield to the general interest. In essence the aim has been to differentiate between types of activity that are and are not protected by the principle of autonomy both generally, and in the context of HIV infection.

The experience of legislatures attempting to use the criminal law to control the incidence of homosexuality, prostitution and drug use was examined. It was noted that the criminal law has failed to eradicate these activities. Indeed, the prosecution of these practices has little to commend it. Prosecutions have been rare for homosexuality and prostitution where the conduct is consensual and occurs in private. By contrast, the prosecution of drug use has been more widespread but prohibitions have not been successful in eradicating the conduct. As a result, public support for the continued proscription of victimless crimes such as these is questionable and the legislatures in many countries including Australia have succumbed to group pressure or public opinion by decriminalising the conduct.

History has revealed that legislation is not a suitable weapon to deal with personal morality, or impose a pattern of moral behaviour, since it is intrusive, ineffective, and in some ways quite self-defeating. In fact the introduction of moralism into the AIDS debate serves little purpose, for society will never agree on morality. The issue of morality will always be seen by those who do not share it as representing an attempt to capture State power for sectional ends. By its nature, moralism tends to be blind to the bad consequences that imperfect compliances with the laws may cause. In this respect morality can become a subjective criterion upon which to base laws.

The legal moralist argument requires that the conduct merely be wrong as opposed to harmful. As such it is not in the 1990s a sufficient reason to

impose criminal punishment because in the context of AIDS it will lead law enforcement agencies to focus on the 'classic' wrongful conduct such as prostitution, homosexuality and drug use. Thus, to allow the prosecution of HIV transmission could conceivably lead to a 'witch-hunt' of individuals among the high-risk groups. Surveillance of activities associated with HIV infection would be as difficult as any presently encountered. This may result in the development of ineffective ways to deal with the spread of the disease which could drive the high-risk activities 'underground.' Although some respect ought to be given to those in society who believe transmission of HIV is immoral that in itself cannot become a respectable moral argument on which to base criminal legislation. As Feinberg has stated, for morality to have the effect desired, it must be enforced 'fearlessly but ferociously [in a manner] that shows no respect for anyones privacy'.<sup>166</sup> If legal moralism were to win in this debate, then HIV transmission could be indirectly criminalised without reference to the harm it might cause either to oneself or to others.

The harm principle itself was also examined in some detail. It was recognised that few would take issue with the fact that the criminal law should act to prevent harm to others. But, not all harm must necessarily be regarded as criminal. Admittedly the harm arising from HIV is different from the harm arising from drug use; the latter essentially non life threatening. However, it has not been proven that the public fear criminal conduct involving HIV as much as rape or robbery.<sup>167</sup> No criminal theorist has clearly stated why it is that some harms are treated as civil and others treated as criminal or why former classifications should still hold weight in the 1990s.<sup>168</sup> The current differentiation is likely to be supported merely by administrative convenience rather than by philosophical principle. Just because a harm is life threatening does not mean that it is only the criminal law that should have jurisdiction. It is generally accepted that public health authorities should intervene in a quarantine sense where life threatening

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<sup>166</sup> Feinberg, *supra* note 61, at p. 82 which was earlier implied by Packer when he said that the criminal sanction is the best available device for dealing with gross and immediate harms and threats of harm but it becomes largely inefficacious when it is used to enforce morality. (*The Limits of the Criminal Sanction*, Stanford, Stanford University Press, 1968, at p. 365).

<sup>167</sup> In fact studies on the fear of certain crimes have not yet included fear of HIV-related crime as a category.

<sup>168</sup> Indeed, it has been cogently argued by MacKinnon that rape, for example, should not be regarded as a criminal act but as a civil one (MacKinnon, C., *Feminism Unmodified: Discourses on Life and Law*, Cambridge, Harvard University Press, 1987, chapter 7).

illnesses such as cholera are involved. In fact, from the standpoint of history alone, the criminal law has rarely intervened to curb the spread of disease. A strong case can be argued for placing primary responsibility for curbing the spread of HIV on public health departments. This theory will be developed through chapters three, four and five of this thesis.

A strong paternalistic rationale for criminalising HIV transmission would not be justified. One can conceive of governments closing down gay bath houses and providing quarantine for an HIV-infected person as necessary for his or her own protection. Evidently, a majority of the populace would see these measures as an unjustifiable intrusion into the lifestyles of consenting adults. In fact, this example indicates how 'hard' paternalism can conflict with the harm-minimisation approach. In any event, it is possible that a 'soft' version of paternalism can be and is currently accommodated under the auspices of preventing harm to others. Drink-driving legislation illustrates how the criminalisation of acts calculated to cause harm to others may also prevent harm occurring to the agent himself or herself. If a stronger version of paternalism is adopted by governments there is the potential for unjustified invasions of personal liberty to occur in a manner similar to that seen when the criminal law aims to enforce morality.

A harm-minimisation approach to law and order is current in Australian society. Under this paradigm only those acts of HIV transmission calculated to cause harm to others would be acceptable for prosecution either on philosophical grounds, on the grounds of efficiency or by support of the majority of the populace. Existing legislation developed with a view to curbing the incidence of homosexual activity, prostitution and drug use should not be used to seek out and prosecute HIV-infected persons engaging in consensual activities which may place others 'at risk of' transmission. Such an indirect means of prosecution would be isolating in effect. It would contradict other pragmatic and integrating approaches to curbing the spread of HIV such as the establishment of needle-exchanges. The question that remains, is how to deal with the recalcitrant HIV-infected person and the individual who uses HIV in a threatening manner to carry out a course of criminal conduct. In the next chapter it will be examined whether acts of HIV transmission calculated to cause harm to others could be prosecuted *directly* under existing criminal law principles or whether express provision would need to be made for them.

## CHAPTER 3

### THE CRIMINAL LAW ASPECTS OF AIDS

#### 1. INTRODUCTION

In chapter two it was concluded that, although the criminal law has generally not been successful in imposing a pattern of behaviour upon individuals, if that behaviour results in harmful acts which intrude into the lives of other members of society then it is the duty of law makers to proscribe such intrusion. The intentional or reckless transmission of a death producing infection is just as dangerous as other behaviour that the criminal law already prohibits.

In chapter two it was recognised that although there are a number of ways by which the criminal law could be used to criminalise the transmission of HIV, the indirect method should be avoided. This chapter will consider whether direct criminalisation by the application of traditional offences to HIV transmission would be the more appropriate course. The third method which would involve the establishment of an HIV-specific offence will be canvassed in some detail in chapter four.

In most common law countries the intentional or reckless transmission of HIV would be punishable under traditional criminal law principles and under public health legislation. However, studies early in the epidemic from the United States <sup>1</sup>, the United Kingdom <sup>2</sup> and Canada <sup>3</sup> reveal that the causation and evidential problems associated with the prosecution of HIV transmission related offences have resulted in some prosecutions being

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<sup>1</sup> Gostin, L., 'The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties' (1989) 49 *Ohio State Law Journal*, 1017-1058.

<sup>2</sup> Forlin, G., and Wauchope, P., 'AIDS and the Criminal Law', *The Law Society's Gazette*, 25 March 1987, 884-885. Laurie, G., 'AIDS and Criminal Liability Under Scots Law' (1991) *Journal of the Law Society of Scotland*, August, 312-318.

<sup>3</sup> Ducharme, T., 'Preparing for a Legal Epidemic: An AIDS Primer for Lawyers and Policy Makers' (1988) XXVI(3) *Alberta Law Review*, 471-520. This point is also reflected in an article describing the preliminary inquiry on charges relating to having sex while knowingly infected with HIV (Johnston, C., 'Controversial AIDS-transmission case sent to trial by the Ontario Judge', *Can Med Assoc J* 1992, 147: 522-523).



dropped or cases dismissed. This awareness prompted the American Bar Association to conclude:

HIV-specific sanctions should play a limited role in combating the HIV epidemic, ... prosecutions under traditional criminal laws pose extraordinary proof problems ... these obstacles will not disappear if HIV-specific statutes are enacted.<sup>4</sup>

This chapter will examine whether the same conclusion can be drawn in relation to criminalising transmission in the Australian context by considering liability for transmission of HIV under pre-existing criminal law provisions. The chapter will also analyse whether criminal activity involving the use of infected syringes can be accommodated within existing provisions.

## **2. CRIMINALISING THE TRANSMISSION OF HIV UNDER PRE-EXISTING CRIMINAL LAW PROVISIONS**

A number of criminal law provisions and principles would be applicable to HIV transmission. Those offences, most likely to be invoked to punish transmission of HIV include murder and manslaughter, now that liability for the death of a person where HIV has been transmitted is practically open in some Australian jurisdictions. This is due to the widespread abrogation of the 'year and a day rule' which formerly applied to all homicides and is explained below. In addition to homicide, attempted murder, assault, various sexual offences and other miscellaneous offences, may be raised depending on the circumstances surrounding the criminal activity involving HIV. All these offences will be considered with reference to the common law which is still an important source of the criminal law in Victoria, South Australia and New South Wales and by reference also to the *Criminal Codes* of Western Australia, Queensland, Tasmania and the Northern Territory, which upon their enactment abrogated the common law rules with respect to crime in those four States.

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<sup>4</sup> 'Criminal Laws Will Not Play a Big Role in AIDS, Judges Told' (1989) 20(8) *Criminal Justice Newsletter*, 1-3 at p. 2.

## MURDER

If a person infected with HIV were found to have transmitted the virus to another with the result of causing that person's death, he or she might be charged with murder or manslaughter. Murder is distinguished from the lesser crime of manslaughter by the more culpable state of mind required for a murder conviction. For an individual to be found guilty of the crime of murder a number of elements must be proved by the prosecution. The fact that HIV infection may or may not progress to AIDS can present major difficulties for the application of the criminal law.

For a successful homicide conviction, the criminal law requires that the accused perform a voluntary act which causes the death of V.<sup>5</sup> A causation problem arises given the characteristics of HIV infection. Causation may be more difficult to prove in the context of AIDS where the victim has engaged in multiple high-risk activities.<sup>6</sup> In chapter one it was stated, that despite one study to the contrary, HIV is unlikely to be spread by one sexual contact with the infective agent. The risk of infection increases or decreases depending on the activity involved. For example, it is more likely that AIDS would be transmitted by either sexual intercourse or the injection of contaminated blood than by spitting or biting.<sup>7</sup> US prosecutors can be criticised for proceeding with cases where the mode of transmission is low

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<sup>5</sup> s. 270 W.A. Code; s. 291 Qld. Code; s. 153 Tas. Code; s. 162 N.T. Code; s. 18 Crimes Act (1900) N.S.W., and *R v Royall* (1991) 100 ALR 669; *Hallet* [1969] SASR 141 (S.A.). Historically the law has created convenient fictions to remedy a causation problem. An example is the principle developed in *Thabo-Meli* [1954] 1 All ER 373. This was a case in which a series of acts occurred but the act causing death was unaccompanied by intent. The court held that it would be sufficient if an intent to kill existed at the outset. Therefore, contemporaneity of the mental state and the act causative of death would not be required. Another example is the case of *Hallet* which supports the 'operating and substantial contribution' theory. In this case, the court considered the situation where the accused commits one act not capable of causing death but V dies from a subsequent act of a third party or intervening agent (human or nature). The court held that where A's first act is still an operating and substantial cause at the time of death the accused will still be criminally responsible.

<sup>6</sup> Even though DNA testing has advanced to the stage where it is now possible to determine the source of HIV infection and hence confirm the identity of a perpetrator this may be of little use in circumstances where the sexual partner (thought to be the infected agent) is unknown to the person who has acquired the infection from him or her. This dilemma will be exacerbated where the victim has had many anonymous sexual partners. Apparently, the only way a person could be traced conclusively is if the DNA codings of the population were to be taken at birth and stored in a data-bank. Such a development has privacy and data protection implications. The recent development of AIDS gene testing may resolve these evidential difficulties. The new process claims to identify, to a high degree of probability, the particular person who transmitted the virus (*The Sunday Telegraph*, July 19 1992, at p. 1.)

<sup>7</sup> see studies listed in footnote 79 in chapter one.

risk, for example, where spitting or biting is involved.<sup>8</sup> Experience from the US reveals that litigation in the future will likely turn on challenging the experts that are called to give evidence as to the risk and modes of transmission.<sup>9</sup>

In addition, the latency in the development of the disease is an exacerbating factor in this regard. It was shown earlier that the incubation period ranges from six months to five years, or conceivably longer. The 'window period' between when infection occurs and antibodies are detectable by blood testing is now believed to be between four weeks to three months. The longer the duration before the appearance of symptoms or antibodies the more difficult it will be for a jury to be sure that A was responsible for transmitting the infection, especially if V may have subsequently had contact with other high-risk individuals. In addition, the jury may not be satisfied that V was not already infected prior to his or her contact with the accused. The criminal law requires that elements of the crime be proven beyond reasonable doubt.

A further difficulty in relation to homicide (and applicable to manslaughter) is provided by the requirement that death must result within a year and a day from the date of infliction of the injury leading to death, the so-called 'year and a day' rule.<sup>10</sup> Death from AIDS will rarely occur within a year. This outmoded rule has already been abrogated in New South Wales, Victoria, Western Australia, South Australia and Tasmania.<sup>11</sup>

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<sup>8</sup> For example, see *State v Haines* 545 N.E.2d 834 (Ind. Ct.App. 1989) p. 841 where conviction for attempted murder upheld on appeal where contaminated blood was sprayed at police; and, the biting case of *US v Moore* USDC D Minn. No. Crim 4-87-44 and on appeal 846 F.2d 1163 (8th Cir.). The defendant had been charged with assault with a deadly and dangerous weapon. See also spitting cases of *State v Cummings* 153 Wis.2d 603, 451 N.W.2d 463 (Ct. App. 1989); *Texas v Weeks* No. 15-183 (Texas District Ct. Walker City), Nov. 4 1989. 1988). In both these spitting cases the charge was attempted murder.

<sup>9</sup> In *Texas v Weeks*, *Ibid*, a spitting case, the prosecution provided an expert to testify that HIV could be transmitted through saliva and the defence provided an expert witness testifying to the contrary. The jury believed the witness for the prosecution and A was convicted of attempted murder

<sup>10</sup> Formerly contained in 276 W.A. Code; s. 155 Tas. Code; and still laid down in s. 299 Qld. Code. The former applicability of the rule in the common law jurisdictions is supported by Gillies, P., *Criminal Law* 2nd ed, Sydney, Law Book Company, 1990, at p. 574.

<sup>11</sup> The *Crimes (Injuries) Amendment Act* (1990) (N.S.W.) inserted section 17A into the *Crimes Act* (1900) (N.S.W.); the *Crimes Legislation (Miscellaneous Amendments) Act* (No. 2) (1991) inserted s. 9AA into the *Crimes Act* (1958)(Vic.); s. 6 *Criminal Law Amendment Act* (1991) (W.A.); s. 18 *Criminal Law Consolidation Act* (1935)(S.A.); *Criminal Code Act (Year and a Day Rule Repeal) Act* (1993)(Tas.).

It must be shown that A possessed one of the alternative mental elements required for murder. Most Australian States require for a murder conviction that A specifically intend or desire that V die or intend grievous bodily harm to V.<sup>12</sup> The latter would need to be defined to include infection with an incurable, fatal virus as a 'permanent injury to health'.<sup>13</sup>

In the AIDS context, A has to intend that V should die from infection with HIV or intend that he or she will suffer grievous bodily harm from the act which transmits the virus. But, the term intention itself is difficult to define. In fact there is 'no [one] accepted final definition of intention ...'.<sup>14</sup> Intention may be thought of as a purposive concept. Some offences only require a purposive intent to act, others require that the defendant had a purposive intent to bring about a consequence. The concept of intention to produce a result is more complex than that of performing an intentional act. It has long been held that an 'intentional act' is one which the actor knows what he or she is doing and means to do. The notion of intending to produce a result or consequence involves mental processes on the part of the actor which may be relatively complex. There are often questions as to what extent the actor considered the consequences that might flow from the act contemplated.

It would seem logical that where A must intend the consequences to which liability will attach, that knowledge of the likely consequences would be a concomitant requirement. Only section 157(1)(b) of the Tasmanian *Code* statutory definition of murder specifically includes this requirement as part of the mental state for murder. In the context of AIDS, this raises questions such as: must A know he or she is infected with HIV and that transmission could occur by the particular act? It may also require that A receive a positive antibody test result or have symptoms diagnosed as AIDS, prior to the date of the crime as a matter of evidence. This could prove to be costly and elusive as law enforcement officials attempt to track a

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<sup>12</sup> s. 157(1)(a) *Tas. Code*; s. 278, 279 *W.A. Code*; s. 302(1) *Qld. Code*; s. 18(1) *Crimes Act* (1900) N.S.W. The common law position in Victoria and South Australia is set out in *Miller* [1951] VLR 346.

<sup>13</sup> In 1992 the terminology used in s.1(4)(d) of the Western Australian *Criminal Code*, was amended so that a reference to causing grievous bodily harm to a person now includes causing a person to have a 'serious disease'. Therefore, ss. 278 and 279 (the murder provisions) of the *Code* might have application where HIV infection is involved. This issue is discussed in more detail *infra*.

<sup>14</sup> O'Connor, D., and Fairall, P. A., *Criminal Defences*, 2nd ed, Sydney, Butterworths, 1988, at p. 9.

person's medical history to find out if he or she had ever submitted to a test. One can envisage situations where prosecutors may try to rely on A's knowledge of his or her infected status to prove an intention to kill.

In the context of AIDS it may be somewhat easier to prove reckless murder rather than intentional murder. This may be due in part to the fact that intentional infliction of death through HIV would be rare. There are reported instances from the United States where original charges have either been dropped <sup>15</sup> or modified because of the difficulty of proving intention. In *Indiana v Haines*, <sup>16</sup> a prisoner was charged and convicted of attempted murder (which also requires an intention to kill) after spraying contaminated blood on a policeman and medical personnel. On appeal, the judge substituted the verdict of attempted murder for another offence (assault) on the basis that an intent to kill was not established on the evidence. In all Australian jurisdictions similar factual circumstances may lead police to engage in the fairly standard practice of charge bargaining. The health of an accused person in non-AIDS related cases has been held to be relevant consideration when negotiating charges. <sup>17</sup>

When focusing on statutory murder in the common law jurisdictions, only New South Wales specifically includes reckless indifference to life as a sufficient mental state for murder. <sup>18</sup> A person may be said to be reckless with respect to the consequence of his or her actions when he or she foresees that it is likely to occur but does not desire it or foresee it as certain (as is the test required to be satisfied for intentional murder). The fact that the actor must foresee it as likely to occur clearly embodies a subjective test of foresight. <sup>19</sup> The degree of risk that must be foreseen by A before he or she is

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<sup>15</sup> For example, the case of *People v Markowski* where the defendant was charged with attempted murder for selling HIV-infected blood to a Los Angeles blood bank. The charges were later dropped for lack of evidence of an intent to kill. Unreported judgment derived from newspaper releases (Cummings, G., 'Charges Filed Against Blood Donor in AIDS Case', *New York Times*, June 30, 1987: A 18, col. 1; 'Man with AIDS', *New York Times*, March 30th 1988 (reporting that case was dropped)).

<sup>16</sup> Teppencanoe County (Ind) Super Ct. No. S-5585, 1987. Although on appeal to a higher court, the jury's verdict was reinstated on the ground that the jury could find that the defendant took a substantial step towards the commission of the murder (*State v Haines* 545 N.E.2d 834 (Ind. Ct. App. 1989) p. 841.

<sup>17</sup> *Wilson v McCormack*, unreported judgment Supreme Court of Tasmania, 32/1968, per Chambers J.

<sup>18</sup> s. 18(1) *Crimes Act* (1900) (N.S.W.).

<sup>19</sup> In the context of *Vallance* [1961] 108 CLR 56, Dixon CJ stated that Vallance would be convicted of unlawful wounding 'if in firing the air gun he fired towards the girl foreseeing or advertent to the likelihood of wounding her but heedless of such a consequence' (at p. 61)

adjudged reckless, will ultimately depend on the facts and the social value of the activity involved but in general the risk must be substantial.<sup>20</sup>

There is some debate as to whether subsections (b) and (c) of section 157 (murder provisions) of the Tasmanian *Code* both contain foresight elements.<sup>21</sup> Unless recklessness comes into section (b) by way of the requirement that A 'knew his[her] actions were likely to cause death', and that knowledge equals foresight, as held by Brennan J in *Boughey v R*,<sup>22</sup> it is difficult to see from where in the *Code* such a requirement is to be derived. The matter is clearer only if the term 'intention' is held to equal recklessness.

Ascertaining the meaning of the term intention as opposed to recklessness has been further complicated by various judgements at common law with respect to the crime of murder. This has resulted in some controversy as to what position recklessness plays in the crime of intentional murder both at common law and under the *Codes*.<sup>23</sup> In fact, the question that has arisen is whether recklessness is considered part of intent. This has implication for statutory definitions that refer only to the term 'intention'. If intention includes recklessness then the Prosecution may be able to prove a lesser mental state as sufficient for murder under those provisions. In Queensland this question has been settled by *R v Willmot No. 2*<sup>24</sup> where a majority of the court held that recklessness had no place in intentional murder.<sup>25</sup> Similarly, Burbury, CJ in the Tasmanian case of *Vallance v R* stated that

in the case ... of a statutory crime in which a specific intention to bring about a particular result is a defined ingredient, it is not sufficient that the accused foresees the consequences of his conduct and thinks the consequences likely or possible. If he foresees the consequences but does

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and affirmed in *Wilkinson* Unreported decision of the Supreme Court of Tasmania 43/1985 by Nettlefold J, at p. 5.

<sup>20</sup> *Boughey v R* (1986) 65 ALR 609, at p. 624.

<sup>21</sup> Neasy, F., 'The Mental Element in the Law of Murder', Paper presented to the 3rd International Criminal Law Congress, Hobart Tasmania, September 26 1990, at p. 25.

<sup>22</sup> *Boughey v R* *supra* note 20, at p. 633.

<sup>23</sup> Campbell, I. A., 'Recklessness in Intentional Murder Under the Australian *Codes*' (1986) 10 *Criminal Law Journal*, 3-23.

<sup>24</sup> [1985] 2 Qd R 413.

<sup>25</sup> *Ibid.* per Connolly J at p. 418 and Campbell J at p. 416.

not desire them it cannot be said he intends the consequences.<sup>26</sup>

Clearly on his view, recklessness is not part of the mental element for murder under section 157(1)(a) of the Tasmanian *Criminal Code*. Therefore, under the *Codes* (with W.A. and N.T. following suit), if V dies as a result of A transmitting HIV recklessly, then A is not responsible for murder.

In the common law jurisdictions of Victoria and South Australia the position with respect to reckless murder is not as clear. A majority of the High Court of Australia in *R v Crabbe*<sup>27</sup> held that if A did an act 'expecting that death or grievous bodily harm will be the likely result, for the word "probable" means likely to happen ... that state of mind is comparable with an intent to kill or to do grievous bodily harm.'<sup>28</sup> This judgment may support the conclusion that recklessness and intention are the same. However, comparable does not mean identical and later in the judgment the court specifically left open the question whether recklessness and intention were identical.<sup>29</sup> Certainly other passages of the judgment would indicate that the Court believed that intentional and reckless murder are two discrete heads of murder at common law.<sup>30</sup>

The court in *Crabbe* also referred to the concept of wilful blindness as providing the *mens rea* for the crime of murder. The court held that wilful blindness was no substitute for actual knowledge where knowledge is required. Their Honours adopted the view that it cannot be said that an accused was wilfully blind to the consequences of his or her acts unless he or she knew that those consequences were probable. If that is correct, then the doctrine has no part to play in murder given the mental state required at

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<sup>26</sup> (1961) Tas. S.R. 51 at p. 65.

<sup>27</sup> (1985) 59 ALJR 417.

<sup>28</sup> *Ibid*, Gibbs, CJ, Wilson, Brennan and Dawson, JJ, at p. 419. Reckless murder under s. 18 of the *Crimes Act* (N.S.W.) and reckless murder under the common law as expressed in *Crabbe* have one important difference. Under the common law liability extends from knowledge of probability of death as well as grievous bodily harm as the probable event. Under s. 18 reckless murder is not committed where A acted simply with the knowledge of the foresight of grievous bodily harm as a probable event. A would incur responsibility for manslaughter only in those circumstances.

<sup>29</sup> *Ibid*, at p. 419.

<sup>30</sup> *Ibid*, where the court (at p. 419) unanimously followed the judgment of Gibbs J in *La Fontaine*, (1976) 136 CLR 62, at p. 75. Gillies, *supra* note 10, at p. 583 endorses this view.

common law. However, in *Giorgianni v R*<sup>31</sup>, a case which concerned culpable driving causing death, the court also held that it is actual knowledge that must be proved where it is an element of intent and not knowledge which is imputed or presumed. Subsequently, though, in *He Kaw Teh v R*, a case involving a charge of importation of narcotics, Gibbs CJ, with whom Mason J agreed, suggested that if the accused wilfully shut his eyes to the probability that he was carrying narcotics he might be treated as having the necessary guilty knowledge.<sup>32</sup> Brennan J disagreed, relying on *Giorgianni* and holding that a state of mind less than knowledge of the probability would not be sufficient to establish intent.<sup>33</sup>

This clear division of opinion was subsequently resolved by *Bahri Kural v R*<sup>34</sup> and *Pereira v DPP*.<sup>35</sup> It was clarified in both these cases (which concerned the importation of narcotics) that, while knowledge as an ingredient of an offence may be established by inference, it must be established as a fact. The term wilful blindness cannot be used as a basis for imputing knowledge where actual knowledge is not proved. In the context of murder then, it is not sufficient to establish the requisite intent that the accused foresaw only the possibility of death or serious bodily injury, but took no steps to ascertain the magnitude of the risk. At most, wilful blindness might be evidence of the actual knowledge or foresight of the accused but it cannot take its place.

Unless adequately explained to a jury there is a real danger that wilful blindness will translate knowledge into recklessness. This could possibly be avoided by instructing the jury that the Crown must show that A knew other facts suggesting a very high probability of the "fact" the accused was trying to avoid knowing.

Wilful blindness may have some application in the context of AIDS. If A knows that he or she is infected and knows that he or she is likely to pass HIV to his or her victim if safe practices are not adopted then there is good chance that the jury will find that A had actual knowledge and the concept of wilful blindness will be irrelevant. However, if A's conduct can be classified as high-risk and he or she has deliberately refrained from

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<sup>31</sup> (1985) 156 CLR 473

<sup>32</sup> (1985) 59 ALJR 620 per Gibbs CJ at p. 625 with whom Mason J concurred.

<sup>33</sup> *Ibid*, per Brennan J at p. 640.

<sup>34</sup> (1987) 162 CLR 502.

<sup>35</sup> (1989) 63 ALJR 1.



ascertaining his or her antibody status, yet engages in activities with V without adopting safe practices, this 'combination of suspicious circumstances and failure to make inquiry may sustain an inference of knowledge of the actual or likely existence of the relevant matter.'<sup>36</sup> This might be a set of facts where the jury would be invited to draw that inference and this failure to inquire could then be termed 'wilful blindness'. In this context, the term is being used merely as a shorthand expression to indicate circumstances which warrant the drawing of the necessary inference. This does not offend the decisions of *Bahri Kural* or *Pereira* so long as knowledge as an ingredient of the offence, although established by inference, is established as a fact. This could arise under a knowledge provision such as in section 157(1)(b) of the Tasmanian *Criminal Code*.

Section 157(1)(c) of the Tasmanian *Criminal Code* is also relevant. The mental element required to be proved under this section is that the offender knew or 'ought to have known' his or her act or omission to be likely to cause death although he or she had no wish to cause death or bodily harm. The High Court in *Boughey* held that the term 'ought to have known' refers to what the particular accused with his or her capacity and knowledge ought to have known in the circumstances in which he or she was placed. The words do not refer to what he or she would have known if he or she had taken the trouble to find out.<sup>37</sup> It is questionable whether the use of wilful blindness in conjunction with 'ought to have known' would apply in the situation where A did not know he or she was HIV-infected but should have suspected it given his or her practices.

In most cases it is unlikely that the mental state for murder will exist given that transmission of HIV commonly occurs through acts of passion (sexual intercourse) or out of dire need (intravenous drug use). Further, these methods would seem highly indirect for the person whose purpose is to kill. Where the mental element for murder is not established A may still be held responsible for Manslaughter provided that A can be conclusively linked to V's death. The 'year and a day' rule would also be applicable under manslaughter.

## MANSLAUGHTER

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<sup>36</sup> *Ibid*, at p. 3.

<sup>37</sup> *supra* note 20 per Mason, Wilson and Brennan JJ at p. 622.

Both at common law and under the *Codes*, the classifications of manslaughter are divided into voluntary and involuntary manslaughter.<sup>38</sup> Voluntary manslaughter covers the situation where provocation and self-defence are relevant. There are a number of categories of involuntary manslaughter both at common law and under the *Codes*, namely, manslaughter by the intentional infliction of bodily harm, manslaughter by a negligent act or omission and manslaughter by an unlawful and dangerous act. Each will be examined to determine its applicability in the context of AIDS.

#### (i) Manslaughter by Intentional Infliction of Bodily Harm

Manslaughter by intentional infliction of bodily harm applies in the common law jurisdictions and under each of the *Codes* with the exception of that of the Northern Territory. At common law, and in Queensland<sup>39</sup> and Western Australia<sup>40</sup>, manslaughter by intentional infliction of harm has three necessary elements, namely, a battery or assault by application of force accompanied by an intention to inflict physical injury or bodily harm with death resulting.<sup>41</sup> In Tasmania, the scope of liability is broader.

Under section 156(2)(a) A must either perform 'an act intended to cause death or bodily harm, or which is commonly known to be likely to cause death or bodily harm ...' and which is not justified by any other provision under the *Code* (such as self-defence). Bodily harm has been defined as including 'any hurt or injury calculated to interfere with health or comfort ...' (*R v McCallum*<sup>42</sup>). The term 'commonly known' has been defined to mean 'matters of common knowledge of men to be related to conduct to be expected of a reasonable man in the circumstances'. The words thus express an objective as distinct from a subjective criterion of conduct' (*Phillips*

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<sup>38</sup> In jurisdictions where the criminal law has been codified a definition of manslaughter is provided (s. 303 Qld. *Code*; s. 156 Tas. *Code*; s. 163 N.T. *Code*; s. 280, W.A. *Code*). Only under the Tasmanian *Code* is a very detailed definition provided (s. 156).

<sup>39</sup> ss. 23, 300, 303 Qld. *Code*.

<sup>40</sup> ss. 23, 277, 279 W.A. *Code*.

<sup>41</sup> *Holzer* [1968] VR 481 per Smith J at p. 482.

<sup>42</sup> [1969] Tas SR 73, per Burbury CJ at p. 88.

*v R* <sup>43</sup>) and it is sufficient under this section that there is an objective likelihood of bodily harm.

The view has been expressed that the term 'act' in section 156(2)(a) 'comprehends acts which would be lawful but for the fact that such acts are, objectively considered, "likely to cause death or bodily harm" '. <sup>44</sup> If there is nothing in the *Code* to justify A's act then the homicide is culpable. There is no requirement that the act causing death be an assault or otherwise unlawful. This view means there is a distinction between section 156(2)(a) and (c) because the latter refers to acts that are independently unlawful.

Accepting this view, the 'act' in the context of transmitting HIV under section 156(2)(a) could be a lawful one such as sexual intercourse. However, if the act is viewed solely as this then it is unlikely A would be convicted. This is because an act of sexual intercourse simpliciter would not, on the wording of the section, be an act 'commonly known to be likely to cause death'. The act should be viewed in its context as suggested in the non-AIDS related case of *Fleeting v R* <sup>45</sup>. Following this view, the 'act' could then be termed 'transmitting HIV'. This would more likely satisfy the requirement that the act be 'commonly known to be likely to cause death or bodily harm' and would cover the situation where A knew he or she had the virus but did not intend to kill V. However this formulation of 'act' could be criticised since viewing the act as 'transmitting HIV' would include both the act and the consequence and would be contrary to authority which prefers a narrow view of 'act' (not including the result) to be adopted. <sup>46</sup> Perhaps defining the act as 'sexual intercourse in circumstances of HIV infection' would be more appropriate.

Since HIV infection is really the transmission of bodily fluids it may be questioned whether the transmission could be a willed act. The exchange of bodily fluids may be regarded as an involuntary reflex action. Justice Windeyer's judgement in *Ryan* <sup>47</sup> may be relevant to resolving the

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<sup>43</sup> [1971] ALR 740 per Windeyer J at p. 758.

<sup>44</sup> per Brennan J in *Boughey v R*, *supra* note 20, at p. 634 and supported by earlier case of *Phillips*, *Ibid*, per Windeyer J at p. 757.

<sup>45</sup> [1977] 1 NZLR 343.

<sup>46</sup> from the case of *Vallance*, *supra* note 19. However, It could be argued that the consequence is something other than transmitting HIV, such as developing AIDS (which is a consequence which follows from transmission at a later time).

<sup>47</sup> (1967) 121 CLR 205.

matter. In that case His Honour held that the accused could not argue that his act of shooting was unwilling simply because he depressed his finger on the trigger following the victim's sudden movement towards the alarm button. Justice Windeyer stated that where an accused performs all the prior necessary steps such as loading, cocking, aiming the rifle and removing the safety catch, he or she cannot claim that the subsequent shooting is a reflex action. Similarly, if for example, an infected male finds himself in a position where he does not intend to exchange bodily fluids during sexual penetration but it occurs, he could not reasonably argue that this was involuntary when he has placed himself in a position where he may not be able to exercise control.

An analysis of the second limb of section 13 (Tas.) or 23 (Qld., W.A) also raises the 'defence' of accident. The test that has been applied to this limb is that the event or injury to qualify as an accident, must be unintended, unforeseen and unforeseeable by the doer of the act.<sup>48</sup> A further qualification was made to this foreseeability test in the case of *Boughey*. In this case, a doctor pressed on the victim's carotid arteries during lovemaking. He believed that it increased her passion. However, the pressure was too great, and the victim died. The doctor claimed that the event occurred by accident. The court disagreed, stating that a reasonable person in the doctor's position, and with the doctor's knowledge would have foreseen that pressure on the carotid arteries could reasonably lead to death. Thus, the event was not an accident.

When applying this reasoning to a case of HIV transmission two points can be made. First, following *Boughey*, if a person is aware of being HIV positive but does not believe that transmission will occur, the knowledge of his HIV status will be attributed to the reasonable person in determining whether the event was reasonably foreseeable. Second, although the probability of transmission of HIV through one contact with the infected agent is low, the test of accident is one of foreseeability not probability. It is likely that a jury faced with the gravity of the possible harm and the relative ease of reducing the risk through the adoption of safe sexual practices, would be likely to find that the resulting transmission was reasonably foreseeable and not accidental.

The unlikelihood of an accident defence being successfully raised leaves consent as a justification. The requirement that the act be unjustified under the Tasmanian *Code* would appear to allow A to lead

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<sup>48</sup> By a majority of the court in both *Vallance* *supra* note 19, and *Kapronowski* (1973) 1 ALR 296.

evidence of consent (s. 53). Since the consent defence is most likely to arise in the context of HIV transmission it is necessary to consider it at this point.

The criminal law nullifies consent to death as a defence in all Australian jurisdictions.<sup>49</sup> Section 53 of the Tasmanian *Code* states V cannot consent to death (s. 53(a)) or an 'injury likely to cause death' (s. 53(b)). The Court of Criminal Appeal in *Boughey*<sup>50</sup> equated the term 'injury' in section 53(b) with 'bodily harm'. So if A knows his or her act is likely to cause death or bodily harm, and it is objectively likely to, then, by virtue of section 53, and following the interpretation of the court in *Boughey*, V cannot consent.

However, the Queensland Court of Criminal Appeal in *Lergesner v Carroll*<sup>51</sup> has held that there is no rule of law under the Queensland *Code* that a person cannot consent to bodily harm. If there is a policy judgment to be made to limit the consent which may be given then only the Legislature can provide the limitation by necessary enactments.<sup>52</sup> Both Cooper and Stephenson JJ believed that in all cases it was a question of fact to determine if the degree of violence to the person assaulted exceeded that to which consent was given.<sup>53</sup> The accuracy of this decision is questionable in light of the House of Lords judgment in *Brown*.<sup>54</sup> Although only persuasive on Australian courts, their Lordships did deem consent irrelevant in cases where the conduct concerned was contrary to public policy. The merits of this decision were discussed in chapter two.

The 'defence' of consent could arise in the situation where A told V he or she was infected but V nevertheless consented to the 'risk' of death associated with HIV infection. If V consents to the 'risk' only of death, this may not be within the scope of section 53. However, section 53 of the

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<sup>49</sup> s. 261 W.A. *Code*; s. 284 Qld. *Code*; s. 53 Tas. *Code*. It is a well-established principle of common-law as affirmed in England and Wales in 1993 in the case of *R v Brown* 2 WLR 556 which is discussed *infra*.

<sup>50</sup> Unreported decision of the Court of Criminal Appeal of Tasmania, No. 5/1985 per Gibbs CJ at p. 22 and Cosgrove J at p. 17.

<sup>51</sup> [1991] 1 Qd. R 206.

<sup>52</sup> *Ibid*, per Cooper J at p. 216. This was also the tenor of the dissenting judgments in *Brown* [1993] *supra* note 49 as discussed in chapter two of this thesis.

<sup>53</sup> *Ibid*, at pp. 212 and 217 respectively.

<sup>54</sup> *supra* note 49. The issue of consent is discussed under the section headed 'Assault' later in this chapter.

Tasmanian *Code* specifically states that one cannot consent to the infliction of an injury likely to cause death. Clearly this would mean that the victim's consent would be ineffective. In practice, this would only be relevant to an act of sexual intercourse or needle sharing since it is most unlikely that a person would consent to an act of biting or spitting or being stabbed with a syringe.

(ii) Manslaughter by Negligent Act or Omission

Homicide may also be culpable when A is criminally negligent. This form of culpability for manslaughter is recognised in the common law jurisdictions<sup>55</sup> and the *Code* States <sup>56</sup>(with the exception of the Northern Territory <sup>57</sup>). In the *Code* States however, liability for negligent acts is minimised, the focus being placed more on omissions.<sup>58</sup>

Negligent act manslaughter at common law requires that death is caused by an act which is objectively one of a risk-producing character. It appears that Australian authorities do not require proof of awareness of risk on the part of the defendant, but instead tend to view the offence as proven upon proof of risk-producing behaviour on D's part which is, on an objective view, such as to produce a risk to life and limb and which is to be characterised as grossly negligent.<sup>59</sup> This lack of *mens rea* (i.e. there is no requirement of awareness of risk on D's part) could be problematic for D in a given case. For example, D might have obtained a syringe full of heroin from X and injected it into Y. Y some time later dies from an overdose of pure heroin. D argues that he or she did not know that the syringe contained pure heroin. Would D be regarded as objectively negligent? This may depend if IV drug use is on an objective view regarded as risky to life and limb. This step can be taken further by hypothesising the situation where D a drug user and unaware of the risks of HIV/AIDS injects Y during a heroin shoot-up using

<sup>55</sup> For negligent acts: *Nydam v R* [1977] VR 430, *R v Taktak* (1988) 14 NSWLR 115; for negligent omissions: *Russell* (1933) VLR 59, *R v Taktak*.

<sup>56</sup> ss. 285-290 Qld. *Code*; ss. 262-267 W.A. *Code*; s. 156(2)(b) Tas. *Code* in conjunction with ss. 144-151.

<sup>57</sup> In the Northern Territory, section 154(1)(3) of that *Code* may be applicable (causing death by an act or omission which causes serious or actual potential danger to life, health or safety).

<sup>58</sup> There is no specific reference to negligent acts under the *Codes* although there are provisions pertaining to 'doing dangerous acts' exist in each of the *Code* jurisdictions (s. 288 Qld. *Code*; s. 265 W.A. *Code*; s. 149 Tas. *Code*; s. 154 N.T. *Code*).

<sup>59</sup> *Nydam supra* note 55 at p. 445.

an HIV contaminated needle. Y is later found to be HIV antibody positive and D has transmitted HIV to Y. Given that the community has been well advised about the risks of HIV and, in particular, the use of contaminated needles then objectively D has produced a risk to life and limb which may be characterised as grossly negligent. It is unlikely that the principle developed in *Boughey* whereby the reasonable person is placed in the position of the accused would be applicable. If it was, it would bring a subjective quality to the conduct, conflicting with the theory that a negligent omission is not regarded as an offence of *mens rea*.

Manslaughter by criminal negligence by way of omission has four elements. First, there must be a duty owed by A to V to preserve life. The second element is a breach by omission to perform the duty. The omission must then amount to criminal negligence; and, fourth, the omission must cause the death of V. Under the *Codes* there is no duty unless it is provided for by way of statute.

The most relevant provisions in the context of HIV infection are those that pertain to the duties with respect to handling a dangerous thing. Under section 150 of the Tasmanian *Code*, which is equivalent to section 287 of the Queensland and section 266 of the Western Australian *Codes* respectively

[i]t is the duty of every person who has anything in his charge or under his control, ... which in the absence of precaution or care in its use or management may endanger human life, to take reasonable precautions against, and to use reasonable care to avoid, such danger.

Two difficulties arise with respect to this provision. First, it may be ludicrous to argue that A has charge of HIV and it is under his or her control. If anything, the virus has taken control of A although he or she does control whether it is passed to another person or not. It is more problematic to state that he or she uses or manages a virus like HIV as set out in the wording of the provisions.

The other technical difficulty is how the term 'anything' would be defined or assume relevance in the context of HIV. It is certainly arguable that HIV is a dangerous virus. However, the 'things' that the section has previously referred to have been cars or guns, not a virus like HIV. Given that some criminal activity has involved spitting and biting, a situation could arise where the prosecution may try to argue that the mouth or teeth of an HIV-

infected person are dangerous 'things' for the purpose of provisions like section 150 of the Tasmanian Criminal *Code*.<sup>60</sup>

The issue has been debated in a number of non-AIDS related cases. For example, in *McCallum* Burbury CJ held that section 150 'applies to things which have inherently dangerous characteristics, and require careful handling ...'. This part of the provision could cover HIV. However the provision continues: '... in putting them [the things] to the use for which they are designed if danger to life and limb is to be avoided'. Clearly the last part is not so relevant especially since Burbury CJ then referred to examples such as cars and guns. Burbury CJ also held that the section did not deal with things that were 'normally harmless' and that the provision 'referred to things dangerous *per se*'.<sup>61</sup> It could not easily be argued that a virus is normally harmless.

By contrast the Queensland Supreme Court in *R v Dabelstein*<sup>62</sup>, when considering the corresponding provision in the Queensland *Code*, held that the section did not necessarily apply to things only dangerous *per se*. The court there held that a sharpened pencil was a dangerous thing. This view is supported in the widest sense by the Queensland case of *Jackson v Hodgetts*<sup>63</sup> in which the term 'thing' in the corresponding section 287 of the Queensland/Western Australian *Code* was held to cover a meat preservative, therefore widening the previous scope of the provision. Notwithstanding the case law the section would more appropriately apply to the situation where a lab technician in breach of his or her duty sprays HIV contaminated blood on another person.<sup>64</sup> It would also likely cover the situation where a contaminated needle was left lying around in a house where the other occupants are known to use IV drugs.<sup>65</sup> The section may also apply

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<sup>60</sup> As in the biting case of *US v Moore* (discussed *infra*), text and footnote 164.

<sup>61</sup> *supra* note 42, at p. 77.

<sup>62</sup> [1966] Qd R 411.

<sup>63</sup> *Jackson v Hodgetts* (1989) 44 A. Crim. R. 321.

<sup>64</sup> This may also be regarded as a negligent act contrary to s. 288 of the Queensland *Code*, for example.

<sup>65</sup> This factual scenario bears some similarity to the facts of *Jackson v Hodgetts*, *supra* note 63, where the two accused left a can of soft drink containing meat preservative in a place where they knew it was likely that V would pick it up and drink it. Leaving syringes contaminated with HIV in areas where other persons may come into contact with them is technically covered by other legislation. For example, s. 10(4)(a) of the *Drug Misuse Act* (1988)(Qld.) for failing to dispose of syringes in accordance with procedures. Such an offence is punishable by two years imprisonment. However, the level of punishment for such



where a person injects V with a contaminated needle without V's consent. In this latter situation however, it is more likely that the person intends to pass the virus and so despite the needle being a dangerous 'thing' negligence is not the appropriate state of mind.<sup>66</sup>

The most difficult requirement to prove in respect of manslaughter by criminal negligence is that A must be shown to be negligent. In criminal law a person acts negligently when he or she fails 'to comply with a standard of conduct with which any ordinary reasonable [person] could and would have complied'.<sup>67</sup> The test is objective and it is irrelevant that A did not foresee the consequence of his or her actions. The degree of negligence required to establish criminal liability has been said to be that which goes

beyond a mere matter of compensation between subjects and show[ed] such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment.<sup>68</sup>

Later courts have held that it is preferable to rely on adjectives such as "gross", "wicked" and "criminal" to express the degree of negligence.<sup>69</sup> Overall it appears that as with negligent acts Australian courts view negligent omissions as proved upon proof of risk-producing behaviour which objectively is grossly negligent.<sup>70</sup> If HIV is transmitted to V as a result of A's negligent handling of a syringe which has resulted in V's skin being pierced then A will be criminally responsible for the transmission of HIV, provided the jury are satisfied that the criminal standard of negligence is satisfied on the facts. Despite this, it is unlikely that negligence will be applicable in many factual circumstances of transmission.

### (iii) Manslaughter by Unlawful and Dangerous Act

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an offence would not reflect the gravity of the injury if a person became infected with HIV due to this omission.

<sup>66</sup> In fact, it might be more appropriate to bring an offensive weapons charge.

<sup>67</sup> Hart, 'Negligence, Mens Rea and Criminal Responsibility', in Guest, A. G., (ed) *Oxford Essays in Jurisprudence*, Oxford, Clarendon Press, 1961, at p. 61.

<sup>68</sup> per Lord Hewart CJ in *R v Bateman* [1925] All ER 45 at p. 48. This test has been adopted in Tasmania in *R v McCallum*, *supra* note 42.

<sup>69</sup> *Kong Cheuk Kwan v R* (1986) 82 Cr. App. R. 18 at p. 26.

<sup>70</sup> *Nydam v R*, *supra* note 55 and *Jackson v Hodgetts*, *supra* note 63.

Another form of involuntary manslaughter is that by unlawful and dangerous act. This applies in each of the common law jurisdictions <sup>71</sup> but, under the *Codes*, only in Tasmania. The elements are the same at both common law and under section 156(2)(c) of the Tasmanian *Code*.

For the unlawful act doctrine, it is not sufficient that death result during the course of unlawful activity. In the case of *McCallum* Burbury CJ held that the wounding, which was the injury, made the act unlawful. <sup>72</sup> If that view is applied to the transmission of HIV, the fact that V becomes HIV-infected would make the act of sexual intercourse unlawful and manslaughter. However, it is argued that Burbury CJ's view in *McCallum* which suggests that the act should encompass the result is incorrect and contrary to the principle established in *Vallance*. In *Vallance* the court held that, for the purposes of section 13(1) and the crime of unlawful wounding, the 'act' was the 'physical action of the accused' and did not include the result, the wounding. It is difficult to see how the term 'act' can be given different meanings throughout the *Code*, especially since manslaughter does not require that A intend the result.

However, unlawfulness can derive from the dangerousness of the act in question. The English Court of Appeal in *R v Cato* <sup>73</sup> held that the act of injecting another with heroin was unlawful not because it amounted to an offence but because it was dangerous. The administration itself was not unlawful because V consented, and the fact that the possession of the heroin was unlawful was irrelevant because that did not directly cause V's death. The principle from *Cato* might be used in cases to convict consensual needle sharers who transmit HIV to others.

Both at common law and under the Tasmanian provision, the unlawful act must be independently unlawful of its consequence, death. Under the *Code*, an unlawful act may be one which is unlawful under other

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<sup>71</sup> *R v Larkin* (1943) 29 Cr. App. R. 18. Fisse is of the view that the status of this rule is doubtful and refers to the fact that the Victorian Law Reform Commission proposed that manslaughter by unlawful, and dangerous act be abolished in that jurisdiction, Fisse, B (ed) Howard's *Criminal Law*, 5th ed, Sydney, Law Book Company, 1990, citing Law Reform Commission of Victoria, *Homicide*, Discussion Paper No. 13, Victoria, LRC, 1991, at pp. 65-68.

<sup>72</sup> *supra* note 42, at pp. 86-87. This view was also inconsistent with other statements made in his judgment at pages 85-86 and the view His Honour held in *Vallance*, *supra* note 26 (at pp. 67-68) with respect to the definition of the term 'act' for the purposes of section 13(1).

<sup>73</sup> (1976) 62 Cr. App. R. 41. The decision has been criticised in Brett, Waller and Williams, *Criminal Law*, 6th ed, Sydney, Butterworths, 1983, at pp. 260-261.

*Code* provisions and in the common law jurisdictions under other legislative enactments. For example, administration (or injection) of illegal drugs under the *Poisons Act* (1971)(Tas.) is unlawful and if it results in death would provide the unlawful act for the purposes of section 156(2)(c) of the Tasmanian *Criminal Code*. The administration of narcotic drugs is illegal in all Australian States.<sup>74</sup> The presence of consent may complicate the matter since it is unlikely that a person who consents to sharing a needle contemplates that death will result. If the consideration is always, what did V think he or she was consenting to, then it is unlikely V was consenting to death.

Under the *Codes* there are a number of provisions which in the AIDS context would supply the unlawful element. For example, section 175 of the Tasmanian *Code* renders the act of administering poison or other noxious thing with intent to injure and thereby endanger the life of V, unlawful. Although poison is not defined, in the case of *Clarence*<sup>75</sup> Stephen J held that 'an infection is a kind of poisoning'. It is arguable that transmission of HIV by sexual intercourse, by injection or by spitting or biting would fall within the term 'administer' and would certainly endanger life at the very least.<sup>76</sup> HIV-infected semen may be regarded as a noxious thing.<sup>77</sup> If this section would not provide the unlawful act for manslaughter it may stand on its own (if judges are willing to be flexible with the interpretation of the term 'administer') as a separate charge since it does not require that the victim die within a specific period. There are similar provisions to this in other jurisdictions.<sup>78</sup>

Certainly these provisions would seem the most appropriate for indicting a person who deliberately injects another with an HIV-infected syringe. Some provisions have more direct applicability. For example, section

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<sup>74</sup> The legislation is set out in footnote 1 in chapter two.

<sup>75</sup> (1888) 22 QBD 23, at p. 42.

<sup>76</sup> In the United Kingdom where a similar provision under section 24 of the *Offences Against the Person Act* has been considered there has been a difference of opinion by the Court of Appeal. For example, the court in *Gillard* (1987) 87 Cr. App. R 189 was prepared to construe the term 'administer' broadly whereas *Danes* [1987] Crim LR 682 where the accused squirted ammonia at V, the Court were prepared only to construe the term narrowly.

<sup>77</sup> Although, admittedly this did not succeed in a Canadian case in 1992 resulting in charges on administering a noxious substance being dropped (Eastwood, E., and McKelvey, M., 'AIDS in Ontario', *Lancet*, 1993, 341:1653-1654).

<sup>78</sup> ss. 322, 323(2) Qld. *Code*; ss. 300, 301(1) W.A. *Code*; s. 177 N.T. *Code*; s. 39 *Crimes Act* (N.S.W.) (1900); s. 26 *Criminal Law Consolidation Act* (1935)(S.A.); s. 19 *Crimes Act* (1958) (Vic.).

19 of the Victorian *Crimes Act* (1958) states that the administration without consent of a substance known by the accused to be capable of interfering substantially with the bodily functions of V is unlawful. In addition, the reckless endangerment provision in Victoria (s. 22 *Crimes Act* (1958)(Vic.)), the provision penalising the 'causing' of a grievous bodily disease (s. 36 *Crimes Act* (1900) (N.S.W.)) and the provision prohibiting 'acts endangering life' in South Australia (s. 29 *Criminal Law Consolidation Act* (1935)(S.A.)), would also provide the unlawful act for this type of manslaughter.

Sections 122-123 of the Tasmanian *Code*, which criminalise indecent practices between males, may also supply the unlawful act requirement. This section penalises sexual intercourse between males and would thus cover homosexual activities which spread the virus. Consent is irrelevant to a charge under these provisions.<sup>79</sup> As homosexual conduct has been decriminalised between consenting adults in private in other States<sup>80</sup> then unless such practices took place without consent it would not provide the unlawful act for this head of Manslaughter. In the *Code* States other sexual offences such as rape<sup>81</sup> or sexual assault<sup>82</sup> may supply the unlawful act.

Assault will most appropriately provide the unlawful act for the purposes of homicide and has done so at common law.<sup>83</sup> An assault is occasioned by either (a) a direct or indirect intentional application of force, (b) a threat by gesture to apply force or (c) by an attempt to apply force. Each of the discussed modes of transmission, sexual conduct, needle sharing and biting would qualify as an assault if non-consensual and intentional as they all involve a direct application of force. Assault is discussed in more detail in a later section of this thesis.

The unlawful act must also be an inherently dangerous one. The dangerous act has been defined by Windeyer J in *Phillips* as an act which 'a reasonable man would know was fraught with a risk of serious harm

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<sup>79</sup> This was previously the position under ss. 208 and 211 of Queensland *Code* prior to *Criminal Code and Another Act Amendment Act* (1990) which removed the term 'acts against the order of nature' from s. 208 and replaced it with 'anal intercourse'. The act also decriminalised sexual activity between consenting males above 18 years. Similarly sodomy was decriminalised in Western Australia in March 1990 between consenting adult males, but the age is 21 not 18 in that State (*Law Reform (Decriminalisation of Sodomy) Act* (1989)).

<sup>80</sup> Legislative provisions were detailed in chapter two, footnote 1.

<sup>81</sup> s. 185 Tas. *Code*; s. 347 Qld. *Code*; s. 192 N.T. *Code*.

<sup>82</sup> s. 325 W.A. *Code*.

<sup>83</sup> *R v Holzer* [1968] VR 481 and *R v Wills* [1983] 2 VR 201.

to some person whether or not the accused actor was actually aware of this.'

<sup>84</sup> The requirement of dangerousness is therefore assessed objectively. However, it is accepted at common law in Australia now that, in considering whether a reasonable person would appreciate the danger, the physical features of the situation and the nature of the action of the accused are relevant considerations.<sup>85</sup>

This factor was not alluded to by Windeyer J in *Phillips*. However, the court in *Boughey* held that the circumstances of the accused together with his knowledge were relevant details to be considered in assessing whether a reasonable person 'in his position' ought to have known death was likely under section 157(1)(c). It is likely that a Tasmanian court would adopt a similar view to the test of a reasonable person in connection with manslaughter under section 156(2)(c). Hence, all an HIV-infected person needs to know is that a particular act will expose others to an appreciable risk of really serious injury.<sup>86</sup>

#### ATTEMPTED MURDER

A charge of attempted murder is more logical in the AIDS situation given that a finding of guilt does not depend on the victim dying at all or within a certain period of time. Guilt for an attempt turns principally upon the intent of the would-be perpetrator. However, an attempt may impose liability in situations where it is not desirable. It would potentially apply not only when the victim has not died but when the victim has not yet become infected. Since there is no limitation period with respect to criminal offences this is not too problematic, except that it may be difficult to point conclusively to A as the perpetrator as time passes. Attempt law may reach very few cases, as it requires a specific intention to bring about the desired result, for attempted murder, death. It is also possible to attempt an assault, a sexual assault and grievous bodily harm.

Even if the intention is present the criminal law requires that there must be a proximate act or omission which is not too remote and which is part of a series of events which if not interrupted would constitute the actual commission of the crime. The courts in various jurisdictions have not been

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<sup>84</sup> per Windeyer J, in *Phillips*, *supra* note 43, at p. 758.

<sup>85</sup> *Wills supra* note 83, per Fullagher J at 212-214.

<sup>86</sup> *Ibid.*

able to agree on a universal test of proximity which will determine whether an act is sufficiently proximate to qualify as an attempt.<sup>87</sup>

The position is less complicated with respect to the relevance of impossibility in attempts. Impossibility in attempted murder could arise in the situation where A believed he or she was HIV positive but was not and hence despite A's intent and conduct he or she could not transmit the virus and so commit murder. In this situation it might also be argued that there was not a proximate act. A further example where impossibility might arise is where A is prevented from carrying out his or her purpose because a policeman intervenes and arrests A before A has a chance to stab V with a syringe.

On the authority of *R v Donnelly*,<sup>88</sup> a case based on the New Zealand *Crimes Act* (1961), both instances are examples of what is termed factual impossibility but which still give rise to an attempt. However, where A is not HIV positive, different categories of factual impossibility are conceivably relevant. The situation could be regarded as one where inefficient means are used (labelled category four in *Donnelly*) or one of physical impossibility (category five in *Donnelly*). Category five differs from category four because what A proposes to do is impossible, not by reason of insufficiency or inefficiency of means (for example, the blood is not contaminated with HIV), but because it is for some reason physically not possible whatever means are adopted (for example, cannot transmit HIV without contaminated blood).

The attempt provisions of the Western Australia and Queensland *Codes* (s. 4) and the Tasmanian *Code* (s. 2) are worded similarly to the New Zealand statute. Factual impossibility is not a 'defence' where there is a proximate act under the Australian *Codes*. For example, section 4 of the Western Australian *Code* reads 'it is immaterial that by reason of circumstances not known to the offender, it is impossible in fact to commit the offence.'

The position at common law is different. The majority of the court in the English case of *Houghton v Smith* held that physical impossibility (category five in *Donnelly*) was a 'defence' to a charge of attempt. Although this decision has been reversed by section 1(2) of the *Criminal Attempts Act* (1981)(UK) it is still applicable in some common law jurisdictions in Australia,

<sup>87</sup> This is exemplified in the judgments of the Court of Criminal Appeal (Gibson, ACJ, Neasey and Crisp JJ) in the case of *Haas v R* [1964] Tas. SR 1, and by the diverging views of Sheehy J in *R v Chellingworth* [1954] QWN 35 and Stable J in *R v Williams* [1965] Qld R 86 in Queensland, and *R v Borinelli* [1962] SASR 214 in South Australia.

<sup>88</sup> [1970] NZLR 980 and see the judgment of Turner J at p. 990-993 where he sets out the 6 different scenarios where impossibility may or may not be a defence.

for example, South Australia.<sup>89</sup> Hence where A incorrectly thinks he or she is infected, A would not be held guilty of attempted murder in that State if it was decided that the impossibility fell within the fifth 'Donnelly' category.

In one Australian State, provision has been made for attempted offences involving HIV. Under sections 27 and 29 of the New South Wales *Crimes Act* (1900) an accused faces a maximum penalty of 25 years imprisonment for attempted murder by the administration of 'any poison or other destructive thing.' This charge could cover syringe attacks. In July 1990, a prison warder at Long Bay Jail in New South Wales was injected with HIV-infected blood by a prisoner with a syringe.<sup>90</sup> The prisoner was charged with attempted murder but the charge was later reduced to maliciously administering poison.<sup>91</sup> The accused died from an AIDS related illness prior to trial. His conduct could also have provided the foundation for an assault charge.

## ASSAULT

It has been stated that the an assault may provide the unlawful act for Manslaughter under the unlawful and dangerous act doctrine. However, while it might provide the unlawful act for manslaughter (and murder under s. 157(1)(c) of the Tasmanian *Criminal Code*), death would still have to result within a year and a day from the date of the original injury. A charge of assault though could stand as a separate, more appropriate charge because the victim need not die within a specified period. Assaults in Australian jurisdictions are covered generally by statutory definition and are divided in terms of seriousness between common assaults,<sup>92</sup> assault

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<sup>89</sup> *R v Collingridge* (1976) 16 SASR 117.

<sup>90</sup> 'AIDS jab may bring murder attempt count', *The Mercury*, July 23 1990, p. 1 and 'AIDS stabbing case in court', *The Mercury*, August 7 1990.

<sup>91</sup> Anon, 'Transmission Offences' (1993) 4(2) *National HIV/AIDS Legal Link Newsletter*, 2-3.

<sup>92</sup> s. 61 *Crimes Act* (N.S.W.); s. 335 (Qld.) *Code*; s. 313 (W.A.) *Code*; s. 182 (Tas.) *Code*, s. 188(1) (N.T.) *Code*; s. 39 *Criminal Law Consolidation Act* (S.A.).

occasioning bodily harm <sup>93</sup> and serious assaults/acting with intention to cause grievous bodily harm or wounding. <sup>94</sup> An assault may be committed by:

- (a) a direct or indirect intentional application of force without consent (spitting, <sup>95</sup> biting, sexual intercourse, fighting) which is known at common law as a battery, or
- (b) a threat by gesture to apply force (covers situation where accused threatens to inject V with a contaminated syringe or uses AIDS as an invisible weapon: "if you come near me I will spit on you and I have AIDS") which is known at common law as an assault, or
- (c) an attempt to apply force.

Subject to the existence of consent, a direct or indirect intentional application of force may amount to an assault under the *Codes* if the action is either voluntary and intentional (Tas.) or willed (Qld., W.A., N.T.). <sup>96</sup> Neither poisoning <sup>97</sup> nor communication of disease <sup>98</sup> has been held to be conduct that will constitute a battery/assault. With respect to poisoning it is likely that this view has been taken due to the fact that there has always been a specific provision relating to poisoning. When considering communication of disease, courts have expressed their reluctance to extend assault too far beyond its designated realm.<sup>99</sup>

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<sup>93</sup> s. 59 *Crimes Act* (N.S.W.); s. 339 (Qld.) *Code*; s. 317 (W.A.) *Code*; s. 182 (Tas.) *Code*; s. 188(2)(a) (N.T.) *Code*; s. 31 *Crimes Act* (Vic.); s. 40 *Criminal Law Consolidation Act* (S.A.)

<sup>94</sup> s. 33 *Crimes Act* (N.S.W.); s. 340(2) (Qld.) *Code*; s. 318 (W.A.) *Code*; ss. 114, 170, 172 (Tas.) *Code*; s. 193 (N.T.) *Code* (assault with intent to commit an offence); s. 31 *Crimes Act* (Vic.); s. 21 *Criminal Law Consolidation Act* (S.A.).

<sup>95</sup> *R v Cotesworth* (1706) 6 Mod. Rep. 172 where spitting in the face was held to constitute a battery per Holt CJ. A more recent Australian example classifying spitting as an assault in a non-AIDS related case can be found in *Bennett v Morden* unreported judgment Supreme Court of South Australia per Duggan J., SCGRGA21160, 18.6.92.

<sup>96</sup> per Crisp J in *Vallance*, *supra* note 26, at p. 101 and Macrossan J in *R v McIver* (1928) 22 QJPR 173.

<sup>97</sup> *Lambert* (1976) 65 Cr. App R. 12.

<sup>98</sup> *Clarence*, *supra* note 75. Hawkins J (at p. 54) and Field J (at p. 58) thought that the risk of quite serious harm including the transmission of venereal disease might be freely consented to, making a serious assault 'lawful'. The present writer suggests that this could not have been correct in law even before *Brown*, *supra* note 49, given the majority decision in *Attorney-Generals Reference* (No. 6 of 1980) [1981] 1 QB 715.

<sup>99</sup> Stephen J., in *Clarence*, *ibid*, at p. 39.



As to the mental element for this assault, it has not been conclusively determined if recklessness would be sufficient although it is at common law.<sup>100</sup> The High Court of Australia in *Boughey* held that

the absence of ... hostility or hostile intent towards the person against whom force is applied neither precludes the intentional application of force to the person of another from constituting ... assault under the *Code* nor, of itself, constitutes a justification or excuse for it.<sup>101</sup>

However this case revealed that, at common law, hostility is a required element of an assault although their Honours glossed over the issue of what 'hostility' entailed.<sup>102</sup>

In all Australian States, a threat by gesture to apply force requires that the person making the threat causes the other to believe he or she has the present ability to effect his or her purpose.<sup>103</sup> In addition the threat must be accompanied by a gesture. Words alone would not be sufficient although the common law has held otherwise in *R v Knight*, provided the threat was one of immediate violence.<sup>104</sup>

The mental element for a threat by gesture type assault under the *Codes* was stated by Green CJ in *R v Thornton*<sup>105</sup>, and affirmed by His Honour in *Wood v Beach*<sup>106</sup> and by Kennedy and Smith JJ in *Hall v Foneca*.<sup>107</sup> Their Honours held that in order to prove this type of assault A must threaten V with the intention that V be induced to apprehend fear that force

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<sup>100</sup> Nettlefold J in *Wilkinson*, unreported judgment Supreme Court of Tasmania 43/1985 at p. 4. The common law position is found in *R v Venna* [1976] QB 421 as accepted by the Victorian Full Court in *R v Bacash* (1981) VR 923.

<sup>101</sup> *supra* note 20, per Mason, Wilson and Deane JJ at pp. 618-619.

<sup>102</sup> The court merely referred to Barwick CJ's judgment in *Phillips* (1971) 45 ALJR 467 at p. 472 where quoting from *Hawkins Pleas of the Crown* the Chief Justice suggested that an assault had to be committed in 'an angry, revengeful, rude, insolent or hostile' manner.

<sup>103</sup> *Hall v Foneca* [1983] WAR 309; *Brady v Schatzel* [1911] St R Qd 206; *Thornton* Court of Criminal Appeal of Tasmania, unreported judgment No. 81/1984, confirmed by the wording of s. 182(1) *Tasmanian Criminal Code*. But the belief must be based on 'reasonable grounds': *R v McNamara* [1954] VLR 137; *Rozsa v Samuels* [1969] SASR 205.

<sup>104</sup> (1988) 35 A. Crim. R. 314, now questioned by *Zander v Vartzokas* (1988) 34 A. Crim. R. 11.

<sup>105</sup> *supra* note 103, at p. 9.

<sup>106</sup> unreported judgment Supreme Court of Tasmania, 39/1985 per Green CJ at p. 3.

<sup>107</sup> *supra* note 103, at pp. 313-315.

may be applied to him or her. Therefore it is the defendant's intent not the victim's belief that is relevant. Green CJ has been criticised for this opinion because if one follows his judgment to its logical conclusion, it is possible to assault a sleeping person. Nettlefold J in *R v Wilkinson*<sup>108</sup> can be said to have questioned the accuracy of this view given that he held V had to be aware of the threat. This point was also confirmed by a majority of the court in *Hall v Foneca*. Being aware of a threat and fearing injury are slightly different circumstances. It may be that a person is aware they are being threatened by a person wielding an alleged HIV-infected syringe but if they do not believe that is the case they may not fear imminent injury. Hence whether liability is dependent on the defendant's conduct and intent rather than the V's belief is fairly significant.

There is a diversity of opinion in the court in *Thornton* as to the requisite mental element for an assault when it takes the form of a threatening gesture to apply force. Green CJ's view has already been described. Cosgrove J held that it would be sufficient if A either intended those threats or V perceived his conduct as threats.<sup>109</sup> Cox J's judgment gives some support for the proposition that if A acted recklessly as to whether V was induced to apprehend fear he or she would be guilty of an assault, although he made it clear that it was not dependent on him in that case to determine this point conclusively.<sup>110</sup> In *Hall v Foneca* the majority of the court were of the view that V had to know he or she was being threatened and declined to decide whether recklessness would be sufficient. It is doubtful in the AIDS context that the matter of assaulting an unconscious victim would present for argument, since A's victims are nearly always conscious, the threat of HIV infection being used to obtain V's compliance with A's demands. The distinction between awareness of a threat and fearing injury is not adequately grasped by the Judges in these two cases.

At common law there is authority for the view that recklessness is sufficient, that it is enough that A foresees it as possible that V will be put in fear by A's conduct.<sup>111</sup> To be guilty of an assault under the *Codes* or at common law in the AIDS context it would be unnecessary to prove A was

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<sup>108</sup> *supra* note 100, at p. 4.

<sup>109</sup> *supra* note 103, at p. 5.

<sup>110</sup> *Ibid*, at pp. 4-5.

<sup>111</sup> *McPherson v Brown* [1975] 12 SASR 184.

actually infected or carried an infected syringe since all A has to do is intend to induce a state of fear in V that he will carry out his or her purpose and V in fact is fearful of A. Whether A could in fact carry it out successfully is irrelevant.<sup>112</sup> If as a result of A's threats V suffers bodily injury A will be charged with an indirect application of force, or a battery.<sup>113</sup> At common law, it is fairly clear that a mere awareness of the threat will not be sufficient to ground liability. In addition, V must actually fear that injury is imminent. The common law may act as a precedent for interpretation of the Codes where the matter becomes relevant.

Threatening behaviour involving HIV has been directed at police officers acting in the course of their duties.<sup>114</sup> This practical example is a useful illustration both of the factors to be considered in such circumstances and how courts can side-step difficult issues involving HIV.

In all jurisdictions, a person resisting, assaulting or obstructing a police officer in the due execution of his or her duty could be charged for both resisting lawful apprehension and assaulting a police officer.<sup>115</sup> An HIV-infected person may engage in behaviour which aims to prevent officers from arresting him or her. Such behaviour may involve threats of infection. A suspect may either threaten to, or actually engage in, some act such as

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<sup>112</sup> *McPherson v Beath* [1975] 12 SASR 174.

<sup>113</sup> *Zander v Vartzokas*, *supra* note 104.

<sup>114</sup> Many instances have been reported in the media, for example, 'AIDS victim charged', *West Australian*, February 2 1990, which involved an HIV-infected person biting a policeman. 'AIDS biter on attempted murder count', *The Mercury*, July 3 1987, which involved an HIV-infected person biting police officers and rubbing blood from wounds on them. 'AIDS jab may bring murder attempt count' *Sydney Morning Herald*, July 23 1990, recounting the stabbing of a prison officer at Long Bay Jail in Sydney by an inmate. The officer later tested positive for HIV. The inmate was charged with attempted murder but died after a committal hearing. 'AIDS woman on spit charge', *The Mercury*, April 4 1991, concerning an infected prostitute spitting at a police officer.

More numerous are the instances of this threatening behaviour being applied to citizens in the course of criminal activity: 'Warning of attempted murder charges for AIDS syringe threats', *The Mercury*, July 31 1990, detailing use of blood-filled syringes at robberies as a threatening weapon during an assault; 'Assault charge against AIDS man dropped', *The Mercury* February 2 1991, which involved an infected person spitting at an uninfected person; 'Kidnapping plot AIDS threat to wealthy parents', *The Mercury*, March 3 1988, which involved the kidnap and subsequent threat to infect an abducted child with AIDS-infected blood if a ransom was not forthcoming.

<sup>115</sup> S. 114(1)(2), *Tas. Code*; s. 340(2) *Qld. Code*; s. 318(c)(d)(f) *W.A. Code*; s. 20 *Police Act* (W.A.); s. 43(b)(c) *Criminal Law Consolidation Act* (1935)(S.A.); s. 31(b) *Crimes Act* (1958) (Vic.); s. 188 *Code* (1983)(N.T.); s. 33 *Crimes Act* (1900)(N.S.W.).

biting or fighting which may transmit the virus to the officer through blood to blood contact. <sup>116</sup>

In the Tasmanian case of *R v Palmer*, the accused had been informed that he was under arrest after refusing to leave licenced premises when asked by police. In attempting to resist arrest Palmer assaulted the police. The assault included not only inflicting actual physical injury on officers through fighting and biting but also threatening to spit at the officers and kill them since, as he alleged, he was suffering from AIDS. <sup>117</sup> In *Palmer*, an assault by way of threat by gesture under section 182 of the Tasmanian *Criminal Code* was not argued. The fact that the accused threatened to transmit AIDS was not considered relevant to the charge. The charge focused on the physical assault perpetuated by the actual bite under section 114 of the *Code*, which refers to assaulting police officers in the execution of their duty. The accused was later found not to be HIV antibody positive following a test which it appears he consented to.

*Palmer* also illustrates that given the asymptomatic nature of the disease police have little choice but to treat threats they receive from suspects relating to HIV as true and be aware that certain suspects might be carrying potentially HIV hazardous objects. <sup>118</sup> However, excessive use of protective devices to make an arrest should be avoided as these would likely reinforce the irrational fear that HIV could be spread by casual contact. <sup>119</sup>

One of the main obstacles to obtaining a successful prosecution for an assault where the transmission of HIV occurs is the presence of

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<sup>116</sup> The risks of transmission through blood-to-blood contact were considered in chapter one, pp. 28-30.

<sup>117</sup> *R v Palmer* Complaint No. 10282/87 heard in the Supreme Court of Tasmania, August 1987. Palmer pleaded guilty to all counts of assaulting police officers under section 114 of the *Code* and was remanded in custody for pre-sentence and psychiatric reports. From court transcripts.

<sup>118</sup> As depicted in 'Police Fear AIDS attacks', *West Australian*, June 1 1991 where a Victorian Police Association representative is reported as having stated, '[a]ny police officer confronted by a villain with a blood-filled syringe carrying the AIDS virus should get out his gun and shoot him' (per Detective Danny Walsh, Association Secretary). In 1990 the Deputy President of the New South Wales Police Association suggested to police that criminals wielding AIDS infected syringes as weapons should be treated as armed and shot if necessary (per Phil Holder Deputy President in 'Police told to draw their guns on syringe-wielding criminals', *The Mercury*, June 18 1990).

<sup>119</sup> This has occurred in the United States. For example, District of Columbia Police have used disposable clothing, gloves and masks and have escorted suspects from court after bail applications dressed in such protective gear, from Note, 'All Inmates Entering or Leaving Federal Prisons to get AIDS Test' (1987) 18(12)*Criminal Justice Newsletter*, 1-3.

consent. It was stated in *Schloss v Maguire* <sup>120</sup> 'an assault with consent is not an assault at all.' In chapter two it was stated that the criminal law should focus only on non-consensual conduct. The question though is locating the point when apparent consent is vitiated. <sup>121</sup> The Intergovernmental Committee on HIV/AIDS in their 1991 report <sup>122</sup> on control of HIV infection failed to deal adequately the issue of consent in the context of HIV transmission. As the issue of consent is likely to play an important part in most prosecutions for HIV transmission it requires some analysis. The modes of transmission will be considered in turn.

#### (i) Biting, Spitting and Fighting

It is highly unlikely that consent would be raised as a defence to a biting or spitting charge as it rare that a person would consent to being bitten or spat at. Whether the defence would be available in circumstances where HIV was transmitted during the course of a consensual fight where the parties are exposed to each other's bodily fluids needs to be considered. Under some legislative provisions the position is relatively clear. For example, under section 182(4) of the Tasmanian *Criminal Code*, an assault will still be unlawful despite the presence of consent if the conduct engaged in is otherwise unlawful, injurious to the public as well as to the person assaulted and involves a breach of the peace. There is no doubt that fighting would amount to an affray under section 80 of the *Code* and hence satisfy the requirement of otherwise unlawful and would involve a breach of the peace if committed in a public place. Likewise, under the Western Australian and Queensland *Codes* fighting in public <sup>123</sup>, participating in an affray <sup>124</sup> or challenging another to a fight <sup>125</sup> is unlawful. Hence if bodily harm is intended

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<sup>120</sup> (1897) Q.C.R. 337 at p. 339.

<sup>121</sup> As will be seen in chapter four, this question arises with respect to provisions in public health legislation that penalise the transmission of HIV in circumstances where there is an absence of consent. Current public health legislation does not set out the parameters of consent or deal with the matter of fraud as to consent clearly.

<sup>122</sup> IGCA, *Legislative Approaches to Public Health Control of HIV Infection*, Canberra, 1991.

<sup>123</sup> For example, s. 71 W.A. *Code*; s. 93(C) *Crimes Act* (N.S.W.).

<sup>124</sup> s. 72 Qld. *Code*.

<sup>125</sup> s. 72 W.A. *Code*; s. 73 Qld. *Code*.

or likely then, irrespective of HIV infection the conduct would technically constitute an assault.

The common law jurisdictions appear to follow the English common law position since there is no authoritative statement to the contrary. In England, one cannot consent to the infliction of bodily harm in public or conduct offending public morality, for example, sado-masochistic beatings, even if the latter are committed in private.<sup>126</sup> The case of *Attorney-General's Reference (No. 6 of 1980)*<sup>127</sup> established the principle that one cannot consent to bodily harm that is intended or likely. The court held that it is not in the public interest that people should try to cause each other bodily harm for no good reason.

In 1993 in England, the principle in *Attorney-General's Reference* was reaffirmed by the House of Lords decision in *Brown*,<sup>128</sup> a case involving the sado-masochistic activities of a group of homosexual men. Even though the court accepted that, all the actions had been done with the consent of the participants; there was no permanent injury; no infection of the wounds and no evidence of any medical attention being sought, their Lordships still held that the defendants could be charged and convicted of assault occasioning bodily harm under section 47 of the *Offences Against the Person Act* (1861)(U.K). The satisfaction of sado-masochistic desires was not regarded as a 'good reason' for inflicting bodily harm. This decision may have implications for the common law and to a lesser extent, the *Code* jurisdictions in Australia in a variety of circumstances including where HIV infection is involved. Given the facts in *Brown*, where consensual activities do result in bodily harm which cannot be described as either trivial or trifling (as in the transmission of HIV) then there are even stronger grounds for the judiciary to strike out consent as a relevant consideration.

The case of *Brown* raises the question that was debated in chapter two at some length, of how far the State should be involved in regulating relationships by deciding in what circumstances consent may be a defence. On the one hand, not to recognise such a defence would be to ignore liberty on the ground that properly informed adults should be free to take risks that might appear ridiculous to others. However, on the other hand, a paternalistic approach would suggest that it needs to be recognised that

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<sup>126</sup> *R v Donovan* [1934] 2 KB 498 at p. 507.

<sup>127</sup> [1981] 1 QB 715 per Lord Lane.

<sup>128</sup> *supra* note 49.

liberty is not an absolute value and may be necessarily overridden for the purpose of promoting an equally important value, such as preventing the spread of HIV/AIDS. Leaving *Brown* aside, it is at least reasonable that the State would have some difficulty in sanctioning as a defence the conduct of a person consenting to sexual activity that places him or her at risk of acquiring HIV infection.

As the common law position as stated in *Attorney-General's Reference* and by implication, *Brown*, is inconsistent with the interpretation of the *Code* provisions<sup>129</sup> then the examination of consensual conduct in Queensland and most likely Western Australia, would focus on the scope of the consent rather than whether it can be given or not. Likewise, in Tasmania where assaults occur in private and do not involve breaches of the peace, the question should be what in fact did V consent to given his or her knowledge.

It is easy to see how courts might be disposed to hold that fighting was intrinsically harmful in circumstances where one party is infected with HIV and the other ignorant of this fact. But where V is fully informed of the infected status of A and takes part in a fight with A, then commonsense dictates that consent should operate as a defence. In these instances it could be said that V has consented at the very least to the 'risk of' infection.

## (ii) Sexual Intercourse

The issue of consent will also arise when the virus is transmitted by sexual intercourse and V has consented to the act of intercourse. It will always be difficult to ascertain what conversations have taken place between the participants of intimate activities where there is no third person to corroborate the story of either party. In the context of HIV, one of the most concerning features where sexual intercourse is involved, is where A either (a) misrepresents his or her antibody status, or (b) does not disclose his or her antibody status to V. The legal effect of A's behaviour in both instances warrants examination.

### *A misrepresents his or her antibody status to V*

The conduct anticipated in this situation could also be described as fraudulent or deceptive conduct. Most criminal statutes and the common

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<sup>129</sup> due to the decision in *Lergesner v Carroll* [1991] Qd R 206.

law in Australia provide that consent is not freely given if it is procured by fraud.<sup>130</sup> These provisions have application whether one considers assault or the various sexual offences that require consent as an element to be proven by the prosecution. In the absence of a complete statutory definition of fraud, these provisions need to be read with key common law cases on the point.

What appears as a consensual act of intercourse should be rendered non-consensual if V is either not informed as to the infected state of A or is misled as to that state. However, in *Clarence* it was stated that fraud will only vitiate consent if it is fraud as to 'the *nature* of the act itself or the *identity* of the person who does the act'.<sup>131</sup> Since Mrs Clarence knew it was her husband and knew the act was sexual intercourse the concealment by her husband of his condition of gonorrhoea was not relevant to consent and A was not guilty of assault occasioning bodily harm under section 47 of the *Offences Against the Person Act*. This decision can be contrasted with the earlier English decision in *R v Bennett*.<sup>132</sup> In *Bennett*, V was infected with a venereal disease following an act of sexual intercourse with A. The court instructed the jury that they could find A guilty of indecent assault if V did not know A had the disease, even if V could be deemed to have consented to the act of sexual intercourse. The court held that A's concealment amounted to fraud and that fraud vitiated V's consent. The court seems to have adopted a wider view of the term 'fraud' by including the inducing causes.

It may be possible to distinguish *Bennett* from *Clarence* since the partners involved in *Clarence* were married, a fact which was important to the court in the latter case who viewed the wife's consent as implied by law.<sup>133</sup> However, the legal principle which emerged from *Clarence* was endorsed

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<sup>130</sup> s. 2A Tas. Code; s. 319(2)(a) W.A. Code; s. 347 Qld. Code. The common law position is stated in *Papadimitropoulos* (1957) 98 CLR 249 at p. 261 and is set out in statutory form in s. 61R N.S.W. Crimes Act. Victoria has enacted a detailed provision on factors relevant to consent (s. 36). However, fraud *per se* is not one of them. Fraud is covered by a separate section: procuring sexual penetration by threats or fraud (s. 57). The insertion of section 36 in 1991 was arguably motivated by the decision in the case of *Mobilio* (1991) 1 VR 339.

<sup>131</sup> *supra* note 75, per Stephen J at p. 44. Since this decision there has been some intermingling of 'nature' of the act with 'quality' of the act in other jurisdictions, most notably, Canada (*Harms* [1944] 2 DLR 61). This position has not been followed in Australia, see *infra* and Fisse, *supra* note 71, at p. 181; Bronitt, S., 'Rape and Lack of Consent' (1992) 16 *Criminal Law Journal*, 290-314, at pp. 296-298.

<sup>132</sup> 176 ER 925 (1866). This decision was followed a year later in *R v Sinclair* 13 Cox C. C. 28 (1867) where A was found guilty of assault for infecting a twelve year old girl with gonorrhoea. The girl's consent was held ineffective because she did not know of A's infected condition.

<sup>133</sup> *supra* note 75, per Willes J at p. 27-29, 32 and Smith J concurring at p. 37.



by the High Court of Australia in *Papadimitropoulos v R*<sup>134</sup> and affirmed by the Victorian Court of Criminal Appeal in 1990 in *Mobilio v R*.<sup>135</sup> Hence, as the present law in Australia focuses on the nature or character of the act rather than its quality, if A misrepresents his or her HIV antibody status to V and obtains V's consent to sexual intercourse on that basis, V's consent will not be held to be vitiated. This is an area of the criminal law where on its application it could be said that there is a serious deficiency. The current law on fraud as to consent encourages deceptive conduct on behalf of sexual partners which could have catastrophic consequences.

There is one unreported Australian decision where a contrary view to *Papadimitropoulos* and *Mobilio* has been endorsed. Gibson J in *R v Hurst*<sup>136</sup> held that any fraud which procures V's consent will vitiate that consent. This case confirms the *Bennett* view. Unlike the English position as exemplified in *Clarence*, United States courts have held that a woman's consent to sexual intercourse is vitiated by A's concealment of his infection with a venereal disease. This view has been adopted irrespective of whether or not the parties were marital partners.<sup>137</sup>

It appears that whether consent will be vitiated by fraud depends on how the act or conduct is defined. If on the facts of *Clarence* it was defined as 'infection free sexual intercourse' then there would have been no consent on the facts. Similarly in the context of AIDS if it is defined as 'non-HIV-infected sexual intercourse', there would be no consent where A falsely leads V to believe he or she is not infected; there is fraud as to the nature and character of the act. If defined merely as sexual intercourse then irrespective

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<sup>134</sup> (1957) 98 CLR 249. The position has been followed in Tasmania by Crisp J in *R v Schell* [1964] Tas SR 184. The court in *Papadimitropoulos*, *supra* note 130, did use the term 'mistake' rather than fraud which is arguably an extension of *Clarence*, *ibid*. The effect of this is to focus on the victim rather than the defendant, i.e. the victim's mistake and not the defendant's fraud. A mistake as to marital status which precedes sexual intercourse will vitiate consent now under an amended section of the *Crimes Act* (1900) (N.S.W.) s. 61R(2)(a)(ii).

<sup>135</sup> [1991] 1 VR 339. The High Court refused special leave to the Crown to appeal from this decision (1990) 24 Leg. Rep, 14-15.

<sup>136</sup> Unreported decision of Supreme Court of Tasmania 8th June, 1960.

<sup>137</sup> *State v Marcks*, 140 Mo. 656, 657, 43 S. W. 1095, 1097 (1897) where a rape conviction was upheld because V's consent was held vitiated by fraudulent concealment of venereal disease. See *Ex Parte Brown*, 770 Okla. crim. 96, 139 P.2d 196 (1943) where A was held criminally liable for exposing V to venereal disease; and *Epps v State*, 69 Okla Crim 460, 104 P.2d 262 (1910) where A was held liable for infecting his spouse with venereal disease.

of the fact that V believes that A is not infected, V has clearly consented to the act of sexual intercourse and the inducing causes are irrelevant.<sup>138</sup>

It appears however, that unless the view in *Hurst* is adopted, then on the authority of the High Court in *Papadimitropoulos*, when dealing with the offences of rape or sexual assault, a narrow view of 'act' will be taken, i.e. the 'act' must be viewed as 'sexual intercourse'. Similarly, Australian precedent would demand that the 'act' for the purposes of assault must be viewed as 'an application of force'.<sup>139</sup> It may be possible that the courts will choose not to follow such an interpretation given that the disease being concealed is one that results in death whereas syphilis was treatable at least in its early stages. This factor may be a basis upon which to distinguish *Clarence* and avoid the interpretation of the courts in *Papadimitropoulos* and *Mobilio*. In any event, since *Clarence* was concerned with the transmission of disease, and neither *Papadimitropoulos* nor *Mobilio* were, it may be possible to distinguish the latter cases on that ground alone, leaving *Clarence* as the only authority to guide the court. And it may be that 1990s courts will decide that *Clarence* is an archaic authority given that it implied that the wife consented to the transmission of disease on the basis of being simply a marital partner. As marital immunity for rape has now been abolished in both Australia and England<sup>140</sup>, the decision in *Clarence* lacks legitimacy. The

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<sup>138</sup> This point as to inducing causes was clearly stated in *Papidimatropoulos*, *supra* note 130, at p. 261.

<sup>139</sup> This view has been endorsed in the HIV-related Canadian case of *Ssenyonga* (1993) 81 C.C.C. (3d) 257 (Ont. Ct. (Gen. Div.)). The accused who was HIV positive and knew the risks of transmission through unprotected sex, had sexual intercourse with the complainants without informing them that he was seropositive and infected them with HIV. He was charged with aggravated sexual assault and criminal negligence causing bodily harm. The aggravated sexual assault charges were dismissed by McDermid J and the accused died before the trial on the criminal negligence charges could be completed. McDermid J accepted the defence's argument that the failure to disclose HIV status did not constitute fraud because it did not go to the nature and quality of the act. McDermid J stated 'what created the danger was not the application of force but the presence of the virus ... they did consent to the application of force inherent in the acts of sexual intercourse, which force was not in itself excessive or dangerous'. McDermid also refused to import a requirement of informed consent into the criminal law. The decision itself is surprising given that the terminology in the Canadian Criminal Code in s. 263(3)(c) (which deals with consent for all assaults including sexual assaults) had changed in 1982 from 'false and fraudulent representations about the nature and quality of the act' to 'fraud' simpliciter. There is previous dicta in Canada which suggests that where the term 'fraud' appears simpliciter, it should be read more widely (Spence J in *R v Bolduc and Bird* [1967] 3 CCC 294, [1967] 2 CRNS 40, at p. 45 (SCC), and *R v Maurantonio* [1968] 2 CCC 115, at p. 117, 2 CRNS 375, 65 DLR (2d) 674) where Laskin JA believed the case should be treated as one of assault not indecent assault. He pointed out that there was a difference in wording between the assault and indecent assault provisions in that under the former the 'test is wider in that only fraud is required').

<sup>140</sup> *R v L* (1991) 103 ALR 557 abrogated the dubious common law rule that by marriage a wife gave irrevocable consent to sexual intercourse with her husband. In England during

House of Lords decision in *Brown* in 1993 may also be seen to have weakened the decision in *Clarence*. Later courts following *Brown* may decide that a person cannot consent to bodily harm simpliciter or bodily harm involving HIV infection for no good reason. An innocent victim should not be held to have consented to contract a disease merely because he or she chose to engage in intimate relations. Certainly such comments have been made in a number of United States cases on the point as early as the 1920s<sup>141</sup> and continuing to the 1980s.<sup>142</sup>

There have been some statutory amendments which may operate to reduce the harshness of the *Papadimitropoulos* line of decisions for a person who consents to sexual intercourse following misrepresentations as to HIV status. For example, following amendments to the *Criminal Code* in Western Australia in 1985, a failure by one sexual partner to inform the other of his or her HIV-infected status may fall under the term 'deceptive' in section 319(2)(a) so as to nullify consent. This would avoid the difficulties that have resulted from the legal interpretation of 'fraud'. In Victoria, section 57 of the *Crimes Act* (1958) was amended in 1991 to create a separate offence of procuring an act of sexual penetration by fraudulent means.<sup>143</sup> The provision would cover the situation where A misrepresents his or her infected status to V as a prelude to obtaining consent to intercourse.

*A fails to disclose his or her antibody status to V*

There is no legislative provision or case-law in Australia which would support the view that the failure to disclose information or some material fact, unaccompanied by any fraud or deceit, may result in a person being charged for a criminal offence. In addition, it is unclear as to whether it would be likely to render what appears to be a valid consent, null and void. Liability only ensues for a failure to act and as stated earlier in this thesis, this liability is only imposed where a person has a recognised duty to act and

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1993 the House of Lords handed down a similar decision in *R v R* [1991] 4 All ER 481 casting doubt again on the decision in *Clarence*, *supra* note 75, which relied on the common law rule.

<sup>141</sup> *Crowell v Crowell* 180 N. C. 516, 103 S. E. 206 at 210 (1920).

<sup>142</sup> *Kathleen K. v Robert B.* 150 Cal. App. 3d 992 at 997, 198 Cal. Rptr. 273 at 276-277 (1984).

<sup>143</sup> Similar provisions exist in other jurisdictions: s. 218(2) Qld. Code; s. 66 *Crimes Act* (N.S.W.); s. 64(b) *Criminal Law Consolidation Act* (S.A.).

breaches the duty resulting in harm to V. This is in contrast to civil law where the matter has been debated in the context of medical treatment. In Australia, where a doctor fails to advise a patient of material risks inherent in the treatment and the latter suffers damage that is not too remote then the patient would have an action based on negligence rather than battery against the health professional. A material risk is one which a reasonable person in the patient's position if warned of the risk would be likely to attach significance to it, or one which a medical practitioner is or should be aware that a particular patient, if warned of the risk would be likely to attach significance to.<sup>144</sup>

It could be said, that where A knows of his/her condition and fails to disclose it then this is akin to fraudulent behaviour, albeit of a passive kind. The criminal law does not appear to draw a distinction between an active type of fraudulent behaviour which occurs in circumstances where the actor knows of, for example, his HIV-infected status or the fact he or she is married but consciously misrepresents a different state of affairs, and, the situation where the actor merely refrains from saying or doing anything. In fact, current case law and legislation would appear to support only the active type of fraudulent behaviour.<sup>145</sup> HIV infection brings to the forefront the deficiencies in current law on this point. In particular, the actor who remains silent is less likely to be prosecuted if it cannot be proven whether he or she underwent an HIV antibody test and was informed of the results prior to engaging in sexual intercourse with V. The present writer suggests that rather than looking to fraud to vitiate consent one can simply suggest that transmission of HIV is beyond the scope of the initial consent. Admittedly, if this view was adopted, sex with an infected person must always amount to rape or sexual assault if the victim is unaware of the infection.<sup>146</sup> However, the known presence of HIV is so inherently dangerous that sex with someone

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<sup>144</sup> *Rogers v Whitaker* (1992) 109 ALR 625, at pp. 633-634. See also chapter six where the matter of informed consent to medical treatment is discussed in more detail, pp. 245-246.

<sup>145</sup> However, in some states (e.g. *Criminal Code* (W.A) s. 319(2)(a)) terminology such as 'any fraudulent means' may cover passive fraud. There is some Canadian authority to suggest that fraud must be a positive fraud (*R v Brasso Datsun (Calgary) Ltd* (1977) 39 C.R.N.S. 1 (Alta. S.C.T.D.)). There is however, one Canadian case where it was held that non-disclosure of employment status amounted to fraud contrary to what is now known as s. 380(1) of the *Criminal Code* (*R v Monkman* (1980) 4 Man. R. (2d) 352 (Co. Ct.)). Whether non-disclosure can stand on its own as a circumstance that will vitiate consent has not been decided.

<sup>146</sup> One could take this position further and suggest that following the principle in *DPP v Brown* [1992] 3 WLR 556 where the victim consents to sexual intercourse with a person who the victim knows is infected with HIV, his or her consent is likely to be deemed null and void as against the public interest. See also chapter two, text and footnote 163 where the case is discussed in some detail.

who is HIV positive extends beyond the norm of scope of conduct initially consented to in the same way that tackling behind the play in a rugby match would be outside the rules of the game and hence outside V's scope of consent. However, in *Ssenyonga* the judge believed that this view was only relevant to assault and not to sexual assault. In sports such as hockey McDermid J held that the concern is about the nature of the force used and whether it exceeds the scope of implied consent; in the case of sex, the degree of force is not related to the risk of being infected with HIV. It is submitted that this decision does not deal with the main argument being raised, that the conduct exceeds that to which consent was given. The problem is getting around what the criminal law has said a person consents to, for example, the criminal act rather than what they really consented to, infection free sexual intercourse or intercourse free from the risk of contracting a serious disease.

### SEXUAL OFFENCES

HIV may also be transmitted during non-consensual sexual activity. Non-consensual sexual assault or rape is an offence in all Australian jurisdictions.<sup>147</sup> Absence of consent is a required element and the issues that will arise on that point have already been covered under heading 'Assault'. In some jurisdictions, if the sexual assault takes place in aggravating circumstances the offence becomes an aggravated sexual assault.<sup>148</sup> Although the provisions relating to aggravated sexual assault do not include A's affliction with a disease as an aggravating circumstance, such a factor could be regarded as such in the future.<sup>149</sup>

Under section 319(1)(a)(i) of the West Australian *Code*, a circumstance of aggravation is defined to include the offender being 'armed with any dangerous or offensive weapon or instrument or [where he or she] pretends to be so armed'. This could cover the situation where V is threatened with a syringe and forced to submit to sexual intercourse out of

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<sup>147</sup> s. 185 Tas. *Code*; s. 325 W.A. *Code*; s. 347 Qld. *Code*; s. 192 N.T. *Code*; s. 611 N.S.W. *Crimes Act*; s. 38 (Vic.) *Crimes Act*; s. 48 (S.A.) *Criminal Law Consolidation Act*.

<sup>148</sup> s. 61(J) *Crimes Act* (N.S.W.); s. 326 W.A. *Code*. In other jurisdictions, aggravating circumstances rather than create a separate offence will command a higher penalty in sentencing.

<sup>149</sup> For example, in the English case of *R v Malcolm* [1988] Crim. LR 189, the risk of a rape victim contracting AIDS was discussed as an aggravating feature in sentencing.

fear that HIV will be transmitted through a needlestick injury. Similar aggravating circumstances are also covered in New South Wales<sup>150</sup> and Victorian legislation.<sup>151</sup> It was unanimously held by all members of the court in *R v Tout*<sup>152</sup> that on a literal reading of section 61(c)(1)(b) (now section 61K) of the *Crimes Act* (1990)(N.S.W.) it is unnecessary for the offensive weapon to be produced to have the effect of a threat under this specific provision.

In *Code* jurisdictions where the aggravating circumstances that the court can consider are specifically listed by way of statute, the inclusion A's HIV status as an aggravating circumstance would not be possible without legislative amendment. However, in Western Australia, section 319(1)(a)(iii) of the *Code* also lists as an aggravating feature circumstances where the offender does bodily harm to any other person. When read with the section 1(4), the interpretation provision in the *Code*, a reference to causing or doing bodily harm to a person includes a reference to 'causing a person to have a disease which interferes with health or comfort'. Hence if an accused were to inflict HIV or a sexually transmitted disease on V in the course of a sexual assault, it would be properly labelled a aggravated sexual assault. Western Australia is one of the few jurisdictions to specifically legislate to cover such circumstances.

Threatening conduct may also vitiate consent in circumstances of sexual assault or rape. In most States and Territories in Australia, threats of violence will render consent null and void.<sup>153</sup> Some jurisdictions also cover the situation where threats are made to V concerning third persons.<sup>154</sup> In the AIDS context the circumstances might well involve an accused person threatening the victim with a needle full of contaminated blood, to engage in sexual intercourse with A. In addition to this being a threat by gesture type assault it would, as already indicated, be either an aggravated sexual assault or rape if V consents to sexual activity, as the consent would have been

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<sup>150</sup> s. 61J(2) *Crimes Act* (1900) (N.S.W.).

<sup>151</sup> s. 41 read in conjunction with s. 38 of the *Crimes Act* (1958)(Vic.).

<sup>152</sup> (1987) 11 NSWLR 251.

<sup>153</sup> s. 2A Tas. *Code*; s. 319(2)(a) W.A. *Code*; s. 347 Qld *Code*; s. 61K(violent threats) and s. 65A (non-violent threats) *Crimes Act* (N.S.W.); s. 92P(1)(a)-(j) *Crimes Act* (A.C.T.); s. 57(1) *Crimes Act* (Vic).

<sup>154</sup> s. 61K(b) *Crimes Act* (N.S.W.); s. 92P(1)(a)(b) *Crimes Act* (A.C.T.); s. 36(b) *Crimes Act* (Vic) stated to be a circumstance where consent would not be 'free'.

induced by threats of bodily harm. Clearly if A threatens V that he or she will stab V with a syringe full of contaminated blood, A is threatening bodily harm at the least. It would also seem sensible that the apprehension would need be reasonable in the objective sense although this is not conclusive from the statutory provisions. Some account needs to be taken of V's views in this regard and of the surrounding circumstances. Arguably, on the grounds of adhering to the principle of 'take your victim as you find him or her', the jury should just consider whether V's fear has destroyed his or her ability to consent. To hold that V's fear must be reasonable in these circumstances would be contradictory to the common law rule relating to rape which states that a defendant's mistake as to whether V is consenting to sexual intercourse does not have to be objectively reasonable.

### SYRINGE RELATED OFFENCES

Needle sharing is an offence under drug-misuse legislation in all Australian States and Territories, irrespective of whether HIV is transmitted or not.<sup>155</sup> However, the ramifications of imposing liability in the context of HIV transmission were canvassed in chapter two with the conclusion drawn that increased prosecutions for drug use would be counterproductive to present policies such as the establishment of needle-exchanges designed to curb the spread of the virus. As stated earlier, if the criminal law is to have a role at all in the context of AIDS, its focus should be on non-consensual harmful conduct. The fact that there have already been reported incidences of

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<sup>155</sup> Needle-sharing is illegal indirectly in all Australian States and Territories. The provisions applicable relate to permitting another to inject him or herself with a prohibited substance or self-administration provisions could be applied to each party. (ss. 5 ('use' defined as including introducing into any part of another person) and s. 12(1) (self-administration) *Drugs Misuse and Trafficking Act* (1985)(N.S.W.); s. 31(1)(b) *Controlled Substances Act* (1984)(S.A.); s. 55(d) (self-administration) *Poisons Act* (1971)(Tas.); s. 74 (injecting another with drug of dependence), s. 75 (self-administration) *Drugs, Poisons and Controlled Substances Act* (1981)(Vic.); s. 6(2) *Misuse of Drugs Act* (1981)(W.A.); s. 169(2) self-administration or s.169(4) permitting another to administer a drug of dependence including cocaine, and s. 171(2)(3) is of the same effect with respect to prohibited substances of which heroin and cannabis are included *Drugs of Dependence Act* (1989)(A.C.T.); s. 13 (self-administration), s. 14 (permitting another to use) *Misuse of Drugs Act* (1990)(N.T.)). Under the *Drugs Misuse Act* (1987)(Qld.) the self-administration of drugs is not criminal. However, under s. 9 of the same Act, possession is, and in a practical sense a user found in possession of a prohibited substance would commit an offence. Section 6 renders it an offence to 'supply' another with a prohibited substance which would technically cover needle-sharing. Further, s. 10(4)(a) states 'a person who has in his possession a thing being a hypodermic syringe or needle who fails to use reasonable care and take all reasonable precautions in respect of such a thing so as to avoid danger to the life, safety or health of another commits an offence against this Act'. Section 10(5) gives police the power of arrest a person found committing the behaviour outlined in sub-section (4)(a). This could be used to harass users in 'shooting galleries' (where needle-sharing is frequent).

robberies and sexual offences committed in Australia using HIV-contaminated syringes as offensive and threatening weapons supports this view.<sup>156</sup>

Clearly a 'threat by gesture' assault charge is appropriate in the situation where A brandishing a syringe threatens to inject V with HIV contaminated fluid if he or she does not comply with A's request. At first glance, a possible causation problem arises because the risk of transmission varies depending on the amount of contaminated substance in or on the needle. However, if the various criminal law provisions are applied to syringe attacks the causation concern becomes irrelevant. Under the provisions, and following *Tout*, it is the threat, and the fact that another person fears for his or her personal safety or submits as a result of the threat, that completes the offence.

The fear associated with contaminated syringes may be completely unfounded where there is a low risk of transmission. Criminals by using them as weapons are elevating the perceived risk of transmission by this mode. If citizens behave as if criminals pose a risk they will enable such persons to continue to hold others to ransom through irrational fear. Admittedly, asking individuals to ignore this type of threatening conduct is tantamount to asking threatened individuals to adopt bold action by standing their ground. Magistrates and Judges need to be suitably dismissive in their approach to these incidents. This will rapidly defuse the myth perpetuated by the media that there is a high-risk of transmission by this mode.<sup>157</sup>

Irrespective of assault, behaviour involving the use of HIV-infected syringes would give rise to other offences. For example, syringe-related offensive conduct could fall within the phrase 'uses any personal violence' in section 240(1)(b) of the Tasmanian *Criminal Code* to give rise to a charge of robbery with violence, or aggravated robbery or robbery under section 393 of the Western Australian *Code*. It would be an offence under section 94 of the *Crimes Act* (1900)(N.S.W.): assault with intent to rob any person (here the charge assumes A does not successfully carry off the property); under section 95: robbery in circumstances of aggravation (where some violence is used); under section 96: robbery with wounding; and under

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<sup>156</sup> Law is gunning for the syringe bandits', *Weekend Australian*, August 4-5, 1990, at p. 5, 'Warning of attempted murder charges for AIDS syringe threats', *The Mercury*, July 31 1990, 'Police near AIDS-threat rape arrest', *West Australian*, July 9 1991. In 1992 in New South Wales, a person who had held up a supermarket with a syringe was convicted of armed robbery under section 95 ((1993) 4(2) *National HIV/AIDS Legal Link Newsletter*, 2.)

<sup>157</sup> Pintos-Lopez, H., 'Reflections on Needlephobia' (1990) *National AIDS Bulletin*, November, 30-32.



sections 97 and 98: robbery with an offensive weapon. Most of these offences carry a maximum penalty of 20-25 years imprisonment. Across the Australian jurisdictions various offences of demanding with menaces, conspiracy to extort money and threats to kill, would also be open.<sup>158</sup>

Under most of the legislation relating to offensive weapons in Australia, a syringe is capable of being regarded as offensive. The definition of an 'offensive weapon' varies across the jurisdictions. Under section 240(1) of the *Tasmanian Code*, although an infected syringe would not fall within the definition of 'offensive weapon' as set out in section 1, it may fall within the term 'instrument' also referred to in section 240(1)(a). An offensive weapon under the *Northern Territory Code* is defined as 'any article made or adapted to cause injury or fear of injury to the person or by which the person having it intends to cause injury or fear of injury to the person.' This is clearly wide enough to cover a syringe allegedly containing HIV-infected blood. By contrast, in the United States a syringe used for injecting poison was held not to be a deadly and dangerous weapon, but merely a vehicle for injecting the poison.<sup>159</sup>

There are many offences in various State criminal legislation which might also have application in the AIDS context where syringes are used. These include possessing an object with an intent to kill or cause grievous bodily harm<sup>160</sup> and being idle and disorderly and in possession of an offensive weapon or anything adapted thereto.<sup>161</sup> However, the penalty for these offences would not match the severity of the injury if HIV transmission has occurred. Hence, they are not useful prosecutorial alternatives to offences against the person.

It is possible that objects other than syringes could fall within the terms of provisions like those in Northern Territory. Although the matter has not yet arisen for consideration in Australia,<sup>162</sup> in the United States the mouth

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<sup>158</sup> s. 99 *Crimes Act* (N.S.W.); s. 35B *Crimes Act* (Vic.); ss. 414, 415 *Code* (Qld.); s. 338, 338A, 396, 397, 398 *Code* (W.A.); s. 166 *Code* (N.T.).

<sup>159</sup> *United States v Narciso*, 446 F. Supp. 252 (E.D. Mich. 1977) at p. 277.

<sup>160</sup> s. 31 *Criminal Law Consolidation Act* (1935)(S.A.); s. 15 *Police Offences Act* (S.A.) where an intention to harm has been held to transform an instrument otherwise innocent in itself into an offensive weapon (*Pelvey v Bresner* [1963] SASR 36).

<sup>161</sup> s. 69(1) *Police Offences Act* (1957)(Vic.); s. 65(4a) *Police Act* (1892)(W.A.); s. 56(1)(d) *Police and Police Offences Ordinance* (1923)(N.T.); s. 6(1)(e) *Vagrancy Act* (1966)(Vic.).

<sup>162</sup> although it could have been in the Tasmanian unreported case of *Palmer* discussed *supra* note 117.

and teeth have been held to be deadly and dangerous weapons regardless of the presence or absence of HIV. This decision in *United States v Moore* <sup>163</sup> was a landmark one which held that parts of the human body were capable of constituting deadly and dangerous weapons, despite authority to the contrary. <sup>164</sup> This was all the more problematic given that there was no evidence on the facts of that case that the skin of the victim had been punctured by the bite. Although the court ignored the AIDS aspect of the case, the decision could be used as a precedent in the United States to find someone who attempted to transmit HIV guilty of assault with a deadly and dangerous weapon. The court held that as the human mouth harboured germs it was capable of being such a weapon. The court in *Moore* reached the same decision as it would have done if it had held the mouth was a deadly and dangerous weapon because of its capacity to transmit HIV. This is somewhat misleading because of the low rate of transmission through this mode.

Since *Moore*, there have been US decisions that have supported this ruling and others <sup>165</sup> which have indicated an uncertainty about whether the human bite is capable of transmitting HIV. Liability in Australia will likely depend upon the interpretation of the relevant statutory provisions which define 'offensive' or 'dangerous' as applied to weapons. It may also depend on the particular advocates performance and the experts that they call to give evidence. The *Moore* case illustrates again how difficult it can be to fit the unique circumstances of HIV transmission into existing definitions for particular offences.

### MISCELLANEOUS OFFENCES

A number of offences not already covered could be applied to HIV transmission. These include transmission offences under public health legislation (to be considered in chapter four), the offence of nuisance and offences relating to conduct endangering life and conduct causing a grievous bodily disease.

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<sup>163</sup> USDC D Minn. No. Crim 4-87-44 and on appeal 846 F 2d 1163 (8th Cir. 1988).

<sup>164</sup> Stansbury, C. D., 'Deadly and Dangerous Weapons and AIDS: The Moore Analysis is Likely to be Dangerous' (1989) 74 *Iowa Law Review*, 951-967.

<sup>165</sup> *Brock v State* 555 So.2d 285 (Ala. Crim. App. 1989) 287-288.

## (i) Nuisance

The offence of Nuisance as contained in the *Codes* and at common law would also be applicable in the context of AIDS.<sup>166</sup> In Queensland section 230 of the *Code* states that a person who

does any act or omits to do any act with respect to any property under his control, by which act or omission danger is caused to the lives, safety, or health, of the public; ... or the property or comfort of the public ... and by which injury is caused ...

would commit a common nuisance. Under the provision the community rather than an individual must be affected. This would have application where HIV is transmitted through the use of needles or the failure to dispose of them properly, although specific offences have been enacted to cover needle disposal in Queensland and the Northern Territory.<sup>167</sup>

There are no Australian cases on point, and under English common law, charges of nuisance based on the communication of disease have concerned the risk of contagion by casual contact.<sup>168</sup> It is possible that a person could be charged with common nuisance where he or she continually places others at risk by his or her sexual behaviour. In the context of HIV, in *Thornton*<sup>169</sup> the Supreme Court of Canada upheld a conviction for common nuisance under section 180(2) of the *Criminal Code* where a person had donated blood knowing that he had twice tested positive for HIV. In Canada, conduct which has the potential to endanger the life, safety and health of the public may constitute a public nuisance, even where the risk of actually causing harm to others is minimal. Given that the terminology of the legislation is similar to that in the Queensland *Code*, it is likely the Canadian decision would be a valuable precedent in that State. It appears that it is unnecessary to prove that a person becomes infected, just that the accused has exposed another person or persons to a risk of infection.

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<sup>166</sup> Contained in Tas. *Code* in s. 140.

<sup>167</sup> For example, s. 10(4) of the *Drugs Misuse Act* (1986)(Qld.); s. 12(5) *Misuse of Drugs Act* (1987)(N.T.).

<sup>168</sup> *R v Vantandillo* (1815) 4 M & Sel 73, 105 ER 762.

<sup>169</sup> (1991) 1 O.R. (3d) 480; (1993) 2 R.C.S. 445.

In another Canadian decision, *R v Summers*,<sup>170</sup> the accused was convicted of nuisance under section 180(2) where he placed sexual partners at risk by having unsafe sex with them after he knew he was infected with HIV. However, in *Ssenyonga* it was suggested that unless a person offered himself to the general public the provision would not be satisfied. On that ground, the charges relating to nuisance were dropped at the preliminary hearing.<sup>171</sup>

The case of *Summers*, is another example where more serious charges of aggravated assault were reduced to common nuisance. If one looks behind the judgment clearly the court was more concerned that the accused did not practice safe sex and overlooked the fact that it is more reprehensible that he engaged in sexual intercourse without telling the victim of his infected condition. Judges must be careful what they communicate to the public by focusing on specific activities and thereby impliedly labelling some (in this instance, safe sex) as more important than others (such as truthfulness as to HIV status). In Australia, it is more likely that this set of facts would lead to a prosecution for another offence which would adequately take into account that the accused acted with knowledge of his infected status.

## (ii) Endangering Life; Causing a Grievous, Serious Bodily Disease

These types of offences have been enacted primarily in response to the AIDS epidemic in New South Wales, Victoria and Western Australia. In New South Wales, maliciously and intentionally causing (or attempting to cause) a person to contract a grievous bodily disease is an offence under section 36 of the *Crimes Act* as amended in 1990. In the future there will need to be a determination whether HIV infection is a 'grievous bodily disease'. If the provision does include HIV infection then the section could be used to charge a person who stabs another with a syringe containing HIV, and, where A transmits HIV to V through sexual intercourse. The section does not cater for reckless activity. Further, it is unclear what role consent would have in determining liability. Since this is a species of assault then it is arguable that it may be raised as a defence.

A 1992 amendment to the interpretation section of the Western Australian *Criminal Code* by the *Criminal Law Amendment Act (No. 2) (W.A.)* inserted a definition of 'serious disease' into the *Code*. Section 1(1) defines

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<sup>170</sup> *Summers v R* (1989) 73 CR (3d) 32 (Alberta CA).

<sup>171</sup> (1992) 73 CCC (3d) 216 (Ont Prov. Div. ) per Livingstone J.

serious disease as 'a disease of such a nature as to (a) endanger, or to be likely to endanger life; or (b) cause, or be likely to cause, permanent injury to health. Section 1(4) states 'In this *Code*, unless the context otherwise indicates -

- (a) a reference to causing or doing bodily harm to a person includes a reference to causing a person to have a disease which interferes with health or comfort;
- (b) a reference to intending to cause or intending to do bodily harm to a person includes a reference to intending to cause a person to have a disease which interferes with health or comfort;
- (c) a reference to causing or doing grievous bodily harm to a person includes a reference to causing a person to have a serious disease;
- (d) a reference to intending to cause or intending to do grievous bodily harm to a person includes a reference to intending to cause a person to have a serious disease.

The effect of the legislation is to render a person who intends to 'infect another person with a disease of such a nature as to endanger, or be likely to endanger life, or to cause, or be likely to cause, permanent injury to health', to be liable for doing grievous bodily harm. Under the *Code*, murder under section 279(1), grievous bodily harm under sections 294(8) and 297 and assault with intent to do grievous bodily harm under section 318(1)(b) would be open in circumstances involving HIV infection as a result of these amendments. In addition, a person who attempts to spread a disease that is non life-threatening but would 'interfere with health or comfort' would also commit an offence. There is one problem with the current definition of serious disease which is the fact that it omits any mention of death. As such, it is possible to argue that the so-called AIDS specific amendments in Western Australia do not even cover HIV/AIDS because HIV is not just 'likely to' endanger life or cause a permanent injury to health. HIV will lead to AIDS which will result in death there being no cure for the disease.

As a result of the amendments, criminal liability is now unacceptably wide as the failure to define 'disease' means that the provision could conceivably cover medical conditions such as the measles. While the theme behind the terminology would appear to be to avoid AIDS exceptionalism, a narrowly directed prosecutorial policy would be needed to prevent the transmission of diseases such as tuberculosis, and other airborne infectious diseases being regarded as criminal. In any event, as the public would not likely support the prosecution of transmission of such diseases

such a provision merely promotes disrespect for the criminal law. There is the danger though that such a broadly drafted provision might be used to prosecute a person infected with TB who is behaving in a way that places another at risk, in order to give credibility to the purpose behind the enactment of the section.

In Victoria under a 1991 amendment to section 22 of the *Crimes Act* (1958), the prosecution is required to prove that A intended to engage in the conduct and that a reasonable person in the accused's position would have realised that his or her conduct would or might place another in danger of death.<sup>172</sup> In Victoria, in 1991 two sex workers were charged under this section of the *Crimes Act* (1958) for conduct endangering life.<sup>173</sup> The charge has since been dropped.<sup>174</sup> In 1992 another charge was laid under the section and at a committal hearing the accused was ordered to stand trial.<sup>175</sup> A further offence has been created by the *Crimes (HIV) Act* (1993) which inserted section 19A(1) 'intentionally causing a very serious disease' (defined in sub-section (2) to be HIV only) into the *Crimes Act*. The offence carries a maximum penalty of 25 years.

The focus on intention and the exclusion of recklessness would fit with earlier arguments about the need to reduce the numbers of persons who might fall within such a provision. However, given that intention is least likely to accompany transmission, there being few incidences of such malicious conduct excepting syringe activities, then it could be argued that its enactment is misdirected. If the argument in favour of its introduction is based on symbolic or educative grounds, it is hard to understand why it was needed given the existence of section 22. Rather than act as a deterrent, such legislation and the media's reporting of HIV-related criminal behaviour may actually fuel criminals to commit certain acts such as syringe-related offences.

Finally, the passage of legislation such as that in Victoria and New South Wales was unnecessary given the amendments to public health legislation in those States which will be analysed in chapter four. In fact,

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<sup>172</sup> *R v Nuri* (1990) VR 641.

<sup>173</sup> Murray, A., and Greenwood, D., 'Endangering Life in Victoria?' (1991) *National AIDS Bulletin*, August, 33-34.

<sup>174</sup> Note, 'Police Face Costs as charges dropped' (1991) *National HIV/AIDS Legal Link Newsletter*, December, at p. 6.

<sup>175</sup> Anon, 'Transmission Offences' (1993) 4(2) *HIV/AIDS Legal Link*, 2-3, at p.3.

there is now an overlap of offences in the criminal and public health sphere. The Western Australian approach is preferable despite definitional problems because an attempt has been made to integrate criminalisation of HIV transmission within existing law by the inclusion of definitions rather than to isolate AIDS as the most dreaded disease, which in terms of history it is not. The amendment which sees the transmission of HIV infection and possibly other sexually transmitted diseases as an aggravating feature in sexual assaults is commendable and long overdue.

It is unlikely that the prosecution agencies in New South Wales and Victoria, States which have the highest incidence of HIV but also with the most vocal AIDS activist groups, would be able to successfully mount prosecutions under such provisions both politically and practically. Prosecutorial policy requires that cases should not be prosecuted unless there is a 'reasonable prospect of conviction'.<sup>176</sup> There are also discretionary factors which would need to be taken into consideration when deciding whether to prosecute, such as the effect on public order and morale; whether the prosecution would be counterproductive; whether there are other alternatives to prosecution; the harsh and oppressive consequences of conviction; the attitude of the victim; and the likely sentence outcome.<sup>177</sup> The legislation does not attempt to remedy the causation and evidential problems addressed in this chapter. It does not appear to aim to educate either. These factors alone render it more probable that such offences are purely meant to be symbolic.

### 3. CONCLUSION

This examination of Australian State and Territory criminal law principles and provisions has revealed that dealing with criminalising HIV transmission through the direct application of pre-existing criminal law provisions relating to the traditional offences of murder, manslaughter, attempted murder, assault, sexual assaults and other miscellaneous offences is generally fraught with difficulties. These include both evidential concerns

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<sup>176</sup> In 1985 the Shorter Trials Committee recommended that a uniform prosecutorial policy be adopted using the reasonable prospect of conviction test. Sallman, P. (ed.), *Report on Shorter Criminal Trials*, Canberra, Australian Institute of Judicial Administration Incorporated, 1985, 50-53. The policy has been adopted in all Australian States and Territories.

<sup>177</sup> These factors constitute the prosecutorial policy followed by Australian DPP's. Brown, D., Farrier, D., Neal, D., and Weisbrot, D., *Criminal Laws: Materials and Commentary on Criminal Law and Process in New South Wales*, Sydney, Federation Press, 1990, at p. 296.

and the problem of malleability of narrow statutes and criminal law principles to cover the transmission of HIV infection. In this respect Australian prosecutors would experience the same problems as those in Canada, the United States and the United Kingdom have done.

For example, no matter how blameworthy or malicious, in a few remaining jurisdictions, a murderer cannot be convicted unless the victim of the accused dies within a specified period because of the applicability of the 'year and a day' rule to homicide. Further, homicide ignores consent as a defence but consent may be a feature of most HIV transmissions. In fact, the offence of homicide does not differentiate between those who inform their partners of their antibody status and those who do not but then neither does assault law. In Australia, the precise terms that an informed consent must take in the context of HIV/AIDS are not covered by existing criminal proscriptions. There is a serious lacuna in the law, a lacuna which existed prior to the advent of HIV with respect to fraud as to consent and the difference to be drawn, if any, between an accused who is actively fraudulent with respect to antibody status and an accused who fails to disclose his or her status. The principle that inducing causes are irrelevant to determining the nature of the act consented to should be outmoded as it currently encourages deceptive conduct on behalf of sexual partners.

As the intervention of the criminal law will be necessary in some situations which involve either the use or threatened use of HIV, it is necessary to have a clear view as to when criminal liability should be imposed. If the prevention of harm should be seen to be the overriding consideration in imposing criminal liability, as stated in chapter two, this aim can be accommodated by treating as criminal only those activities that can be characterised as clear non-consensual wanton acts of aggression or those accompanied by an intent to cause harm. This chapter has revealed that pre-existing criminal law provisions and principles can be used in a few circumstances and it is these circumstances where HIV is likely to be relevant. This would be where A clearly knows of and misrepresents his or her infected status and fails to use protective precautions, either intending to infect another with HIV through high-risk conduct or where A recklessly and not caring or not thinking whether V might become infected or not engages in behaviour that places V at risk of infection. As the former is a highly indirect means of trying to kill another it is unlikely that it would occur with great frequency. It is significant that during the last decade of AIDS in Australia that there has not been one reported incidence of this conduct occurring. It is the



latter activity that is more likely to occur and would include syringe-related criminal behaviour. Assault and attempted murder would be the most relevant offences in the above examples and these offences are the also the most malleable.

However, it is as a result of the perceived inapplicability of existing criminal principles to HIV transmission that some States have enacted HIV-specific offences within criminal legislation. As there are similar offences set out in public health legislation the overlap is questionable and provides some support for the view that the criminal provisions are purely meant to be symbolic; a declaration of what society condemns. Although titles have been given to these new offences such as causing a grievous bodily disease they do not disguise the fact that they are intended for application to HIV. Even though such provisions have been implemented in the US,<sup>178</sup> that does not justify their necessity in the Australian criminal law context. As reported instances of transmission or attempted transmission of HIV have been minimal in Australia, the types of situations most likely to arise for consideration are already covered adequately by existing offences. A separate statutory provision placed among criminal provisions would separate HIV from other forms of disease. Enacting criminal laws meant to apply to HIV/AIDS transmission solely may stigmatise carriers further. Decriminalising conduct such as homosexuality, prostitution and drug use is undermined by the enactment of HIV specific criminal offences which are then used to prosecute sex workers and other more visible groups.<sup>179</sup>

The politics surrounding HIV is readily identifiable by such an act of the legislatures. As HIV is not as contagious as other serious communicable diseases such as TB and Hepatitis B there is no justification for this type of exceptionalism in dealing with HIV/AIDS. Such a stance will bring the law into disrespect. It is not enough to say that we should focus on HIV because death from AIDS will inevitably result from an act of transmission. We should only criminalise and prosecute acts if there is a substantial likelihood that transmission will occur. Viewing transmission in this manner, it is obvious that the transmission of both Hepatitis B and TB should be criminalised as well.

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<sup>178</sup> The legislation is set out in Tierney, T. L., 'Criminalising the Sexual Transmission of HIV: An International Analysis' (1992) 15 *Hastings International and Comparative Law Review*, 475 at p. 499.

<sup>179</sup> see *supra* note 174.

Placing HIV transmission in the sphere of the criminal law by enacting a specific offence increases the scope for moral judgements to creep into the criminal processes. Where juries are involved in the decision-making process irrational fear and prejudice could affect their decisions. There is the potential no matter how well directed by the Judge for jurors to assess guilt by deciding how people should act according to their own moral code. Such moral standards applicable to disease are better incorporated within the realm of public health law. The case for the application of public health laws and more specifically the creation of an HIV specific provision to the spread of HIV in the public health context will be considered in chapter four.

## CHAPTER 4

### **APPLYING AUSTRALIAN PUBLIC HEALTH LAW TO THE TRANSMISSION OF HIV**

#### **1. INTRODUCTION**

Prior to the emergence of AIDS, the only existing forms of liability that directly criminalised conduct that would transmit disease related to contagious diseases. One of the more controversial issues that has arisen with respect to the AIDS epidemic is whether pre-existing public health or criminal law should be applied to curb the spread of HIV/AIDS. Australian State and Territory public health legislative provisions have historically imposed liability on an individual who transmits a communicable disease to another whether it be an airborne disease or a sexually transmitted disease. As these provisions were specifically drafted to deal with the transmission of disease, they may fit HIV transmission more readily than the pre-existing criminal offences examined in chapter three. If this is correct, then there is some support for arguing that penalties for transmission of HIV remain the domain of public health law and not the criminal law.

However, amendments have been made to public health statutes in some Australian States and Territories in recent years that were arguably motivated by the emergence of HIV/AIDS. This was prompted by interested lobby groups who made it clear to legislatures that a 'best fit' could not be achieved by the application of out-moded provisions to the control of HIV/AIDS. In this chapter individual liability under public health legislation for transmitting or attempting to transmit HIV or exposing others to the risk of infection with HIV will be considered by focusing first on the pre-AIDS public health legislation, and then on the post-AIDS amendments. The separation between the two periods of legislative activity will allow focus to be placed on the political processes and societal forces that have underlined amendment in this area. The utility, both practically and politically, of an HIV-specific transmission offence and whether it should be placed within public health or criminal legislation, will also be examined. Overall, the aim of this chapter is to construct a solid basis for why control of the HIV/AIDS epidemic should rest primarily with public health departments. We can begin this quest by examining the historical role of public health departments.

## 2. HISTORICAL ROLE OF PUBLIC HEALTH DEPARTMENTS

It has always been the case in Australia in the sphere of health, that the power to control, to intervene and to provide has rested with the government. Prior to the eighteenth century in both the United States and the United Kingdom this was not the position. Before the development of Boards of Health, the maintenance of health was regarded as an individual's responsibility. There was resistance to the threat of government intervention in health as many in the population saw it as an interference with their private rights.<sup>1</sup> The government's role in matters of health may have been accepted eventually because of the obvious success of public health in most developed countries in improving the standard of living, reducing infant mortality, and, mortality in general from both infectious and non-infectious diseases.

When Australia inherited the English public health system on colonisation, the government presence in health was well-established.<sup>2</sup> It became a colonial and later State government affair. After Federation in 1900 the States conceded none of their powers to the new Commonwealth or Federal government following passage of the *Constitution* (1901). The development of the Commonwealth was instrumental as far as health is concerned in providing the budget for health matters although this role did not coincide with federation itself.<sup>3</sup>

In Australia and elsewhere public health can be regarded as an agent of change, not just for the sake of change but to make possible the achievement of other social goals. To this end, the role of public health departments has been to foster social change and to motivate improvements in health in individuals by changing lifestyles that minimise the potential impact of behavioural and other health hazards.<sup>4</sup> The powers of public health departments have expanded gradually from merely control over sanitation and infectious diseases to controls affecting areas of lifestyle and

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<sup>1</sup> Pickett, G., and Hanlon, J. J., *Public Health Administration and Practice*, 9th ed, St Louis, Mobsy Publishing, 1990, pp. 8 and 99.

<sup>2</sup> Although initially it was a power invoked by the Premier. It was not until the plague epidemic in Sydney in 1900 that Sydney developed a Board of Health. This development only occurred Curson believes due to pressure being placed on the Premier from the New South Wales Branch of the British Medical Association to place discretion for health matters (particularly decisions regarding quarantine) in a Board of Health (Curson, P., and McCracken, K., *Plague in Sydney*, Sydney, New South Wales Press, 1990, p. 168).

<sup>3</sup> Daniel, A., *Medicine and the State*, Sydney, Unwin Hyman, 1990, p. 4.

<sup>4</sup> Davies, B. M., and Davies, T., *Community Health, Preventative Medicine and Social Services*, 6th ed, London, Balliere Tindall, 1993.

behaviour, environmental health, human biology and the organisation of health systems and institutions. During the 1950s focus began to be placed on health education as being the main way to achieve these goals.

One overriding aim that has always been present in public health policy is prevention. The fact that public health officials must think and act prospectively is what distinguishes it as a field of discipline from other branches of therapeutic medicine. Decisions about preventative interventions involve trade-offs: choices involving costs and benefits and choices involving personal freedom and community values. Traditionally public health powers have been broad in the area of infectious diseases. They have included the authority to identify infectious diseases through screening programmes and to require physicians and others to report names of persons suffering from such diseases to the State. Screening and reporting have been accepted as legitimate public health methods designed to protect the health and safety of citizens. The ability to confine persons involuntarily illustrates the broad scope of the State's public health powers.

Public health work is now also interdisciplinary and interorganisational. It has the capacity to draw on wide ranging resources. Even in the past many public health departments have required the police power of government to implement its own powers. Non-governmental organisations were not equipped to perform this function. Historically, police involvement in matters of public health came to the fore during periods of quarantine and originated from the law of nuisance. Quarantine was regarded as abating a nuisance.<sup>5</sup> From that period enforced isolation of individuals was always considered a legitimate police power. Nevertheless, public health departments have always retained the primary power to detain and isolate.

The content of the powers of the public health official<sup>6</sup> as opposed to the police with respect to controlling behaviour that places others at risk of harm is fundamentally different, reflecting the contrast between the overriding aims of the criminal law and public health law. As noted, in the arena of public health, prevention of harm in general is the overriding aim. As a collateral point, historically public health law has been more concerned with preventing danger to society than danger to an individual.

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<sup>5</sup> Curson, *supra* note 2, at p. 168. See also Schwarz, B., *The Law in America*, 1974, pp. 450-46.

<sup>6</sup> These powers are analysed in detail in chapter five.

Although prevention of harm is an aim of the criminal law, in contrast to public health law, it seeks to endorse this aim by acting after the event rather than focusing on preventing a circumstance occurring. In this respect, the criminal law for the most part punishes people for what they have done or failed to do rather than for what they might do. Therefore, the criminal law by its nature must individualise social problems. The individualisation of criminality was a core ideology of the Victorian era.<sup>7</sup>

By contrast public health seeks to minimise the chance that the worst possible outcome will occur. It accepts risks as an essential component of life and tries to manage it in a calculus that combines and estimation of both benefits and costs. Although public health departments have been criticised for laying too much emphasis on individual behaviour as responsible for societal ills,<sup>8</sup> the overriding historical aim of prevention and the infrastructure of public health departments are in alignment with the ultimate theme in the control of the spread of HIV: prevention. In addition, the modern public health or health department has lost many of its functions in the area of mental health and environmental health to outside agencies. This development places public health departments in a prime position to concentrate on the prevention of communicable diseases. An analysis of past and present legislation is necessary to build the case for the responsibility of curbing the spread of HIV/AIDS to remain with public health departments.

### 3. PRE-AIDS PUBLIC HEALTH LEGISLATION

Generally from 1983 across Australia, initially AIDS and AIDS Related Complex were added to the lists of venereal, dangerous-infectious, infectious and/or notifiable diseases under either venereal disease or public health legislation.<sup>9</sup> A number of other provisions became applicable to AIDS

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<sup>7</sup> Norrie, A., *Crime, Reason and History: A critical Introduction to criminal law*, London, Weidenfeld and Nicolson, 1993, at p. 31.

<sup>8</sup> The 1970s tendency of US and Canadian public health departments to lay the blame for drug and alcohol abuse on individuals led to an era of 'victim blaming' which was still in vogue at the time of the emergence of the AIDS epidemic. Public health policy ignored the role that large tobacco and alcohol corporations played in the development and exacerbation of drug abuse. (Pickett, *supra* note 1, at p. 99).

<sup>9</sup> *Venereal Diseases Act* (1918)(N.S.W.), August 1984, AIDS 'A' and 'B' notifiable (former classification for AIDS and ARC respectively) *Public Health (Proclaimed Diseases) Amendment Act* (1985)(N.S.W.), April 1986, AIDS (all categories) proclaimed disease. *Diseases Notification Regulations* (1984)(Vic.) Schedule 3 applicable to *Health Act* (1958)(Vic.) required AIDS, ARC and lymphadenopathy syndrome to be notified, August 1984. Queensland Government Gazette 76 declared AIDS a notifiable disease under the *Health Act* (1937)(Qld.) July 1983. *Health Act Amendment Act (No. 2)* (1984)(Qld.),

by the designation. These included provisions relating to quarantine, isolation or detention, removal to hospital for treatment and compulsory examination orders. In three jurisdictions, Queensland, Tasmania and the Australian Capital Territory, however, only AIDS was added. This is short-sighted because it is unlikely that persons suffering the debilitating effects of symptomatic AIDS would be likely to engage in conduct that may transmit the virus to provoke the implementation of compulsory measures to control them. It is more likely that asymptomatic HIV-infected persons pose a threat to society in this respect. Recognising this, from 1989 onwards HIV has been added as an infectious and notifiable disease in all jurisdictions with the exception of Northern Territory.<sup>10</sup>

A number of pre-AIDS Acts provided penalties for persons who while suffering from any infectious disease exposed themselves in any public place without proper precautions against spreading the disease.<sup>11</sup> The latter

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December 1984, added AIDS to the definition of venereal disease under the *Health Act* (1937). However, under new *Health Act Amendment Act* (1988)(Qld.) ss. 53-58 relating to venereal disease were repealed. AIDS is now referred to as a controlled notifiable disease (s. 32). *Health Act* (1911)(W.A.), AIDS 'A' notifiable, September, 1983. AIDS 'B' (referred to HTLV-III) notifiable January 1985, under *Health-Dangerous Infectious Diseases Order* (W.A.); *Health Infectious Diseases Order* February 1993 designates AIDS and HIV as infectious diseases. In December 1984, AIDS 'A' and 'B' notifiable under *Health Act* (1935)(S.A.). This Act was repealed by the passage of the *Public and Environmental Health Act* (1987)(S.A.), proclaimed in 1989. The first Schedule defines notifiable disease to include AIDS and AIDS related Complex. *Public Health Act* (1962)(Tas.) from August 1983, AIDS 'A' infectious and notifiable disease. AIDS was added to the list of infectious and notifiable diseases under section 13(1) of that Act rather than to the list of venereal diseases, defined in section 3 of the Act. Accordingly any provisions in that Act relating to venereal diseases will have no applicability to AIDS. Schedule 3, *Notifiable Diseases Act* (1981)(N.T.), from July 1983, made AIDS a notifiable disease. In the Australian Capital Territory, the *Public Health (Infectious and Notifiable Diseases) Regulations Amendment* (1980) September 1983, added AIDS to the list of 'notifiable' but not 'infectious' diseases. In the legislation in South Australia, Tasmania, the Australian Capital Territory and the Northern Territory, 'AIDS' is not defined.

<sup>10</sup> *Public Health Act* (1991)(N.S.W.) Schedule 1 and s. 14 specify that AIDS and HIV infection are Category 5 'medical conditions' which are notifiable. Under the *Health (Infectious Diseases) Regulations* (1990)(Vic.) AIDS (as defined in accordance with the Center for Disease Control surveillance case definition of 1987) is notifiable. The *Public Health and Environmental Health (Notifiable Diseases) Regulations* (1989)(S.A.) were amended in 1991 to include HIV as a notifiable disease. In 1989 HIV infection ('all stages') was added to the list of infectious and notifiable diseases by the *Public Health Notifiable Diseases) Regulations* (1989)(Tas.). An amendment to the *Public Health (Infectious and Notifiable Diseases) Regulations* (A.C.T.) in 1992 rendered HIV notifiable. By the *Health Infectious Disease Order* (1993)(W.A.) both AIDS and HIV were declared infectious diseases.

<sup>11</sup> s. 42 of the *Public Health Act* (1902)(N.S.W.); s. 30 *Public Health Act* (1962)(Tas.); section 135 *Health Act* (1958)(Vic.) and s. 264 *Health Act* (1911) (W.A.). Under s. 256 (1)(i)(ii) of the *South Australian Criminal Law Consolidation Act* (1935) a person who wilfully exposes him/herself without proper precaution against spreading any dangerous infectious disease or enters any public conveyance 'without notifying the fact that he is so suffering to the ... driver of the conveyance' is guilty of an offence. Until this provision was repealed in 1992, South Australia was the only State where exposing another to a disease was covered in criminal law provisions.

type of provision is obviously not applicable to a disease like HIV/AIDS that is not spread by social or casual contact or by mere proximity.<sup>12</sup> It is therefore difficult to understand why section 11 of the 1991 New South Wales *Public Health Act* was enacted. Under the section, a person commits an offence if while suffering from a Category 2 (TB) 3, 4 or 5 (HIV infection or AIDS) 'medical condition', is in a public place (includes public transport) and fails to take reasonable precautions against spread of the 'medical condition'. The provision by its terms equates TB with AIDS even though their levels of contagiousness differ markedly. Perhaps the section is aimed at prostitutes which is unacceptable given the fact that the threat of HIV infection posed by this group has been shown to be minimal.<sup>13</sup>

A number of pre-AIDS statutes also contained sections which rendered the transmission of infectious and/or notifiable diseases an offence. This was generally through venereal disease legislation, under which either a fine or a period of imprisonment could be imposed.<sup>14</sup> These provisions were retained in venereal disease or public health legislation for decades. The legislation did not provide a right of appeal for the party convicted. There was also no provision for confidentiality in proceedings to be maintained.<sup>15</sup> In light of this, it is fortunate that venereal disease commanded, in general, an unenthusiastic prosecutorial policy. Transmission offences in New South Wales venereal disease legislation were only repealed in 1988 following the passage of the *Summary Offences Act*. Likewise in Victoria such provisions were repealed in 1990 following proclamation of the *Health (General Amendment) Act* (1988). In South Australia repeal followed the proclamation of the *Public and Environmental Health Act* (1987) in 1989 and in Queensland repeal of such provisions followed the passage of the *Health Act (Amendment) Act* (1988).

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<sup>12</sup> Perhaps this problem was recognised by the Parliamentary draftsman in the Australian Capital Territory, because the *Public Health (Infectious and Notifiable Diseases) Regulations Amendment* of 1983 added AIDS to the list of 'notifiable' diseases only and not the list of 'infectious' diseases. Hence s. 13 penalising exposure whilst suffering from an infectious disease would not apply to an AIDS infected person.

<sup>13</sup> as covered in chapter two of this thesis, footnote 3.

<sup>14</sup> s. 21 *Venereal Diseases Act* (1918) (N.S.W.); s. 25 *Venereal Diseases Acts* (1918-1958) (Vic.); s. 13 *Venereal Diseases Act* (1947) (S.A.); s. 54(12) *Health Act* (1937) (Qld.); s. 310 *Health Act* (1911) (W.A.).

<sup>15</sup> This was with the exception of Western Australia (ss. 312, 314 *Health Act* (1911) (W.A.)).



Prosecutions were laid in some States following contravention of the pre-AIDS provisions. Statistics from Victoria between 1917 and 1920 reveal that 62 orders were issued requiring persons to attend for treatment, 5 prosecutions were laid for disobeying orders, 3 warrants for apprehension were issued, 2 persons were prosecuted for infecting other persons with venereal diseases and 170 male and 129 female prisoners were detained for treatment.<sup>16</sup> Statistics are unavailable between 1921 and the late 1960's. At the Commonwealth level this was due to a gap in compulsory reporting of venereal disease.<sup>17</sup> There was also a haphazard system for reporting among the States with almost no record of prosecutions for offences involving transmission of a venereal disease between these periods. There is one reported instance in 1963 of a male person who knowingly infected another with a venereal disease being sentenced to 9 months hard labour for breach of section 21 of the *Venereal Diseases Act* (1918)(N.S.W.).<sup>18</sup> It is curious that the prosecution of prostitutes or any person or group of persons for transmission of venereal disease was rare since prostitutes were targeted for other types of practices such as compulsory examination and treatment during the Wartime periods.<sup>19</sup>

Despite the repeals already referred to, venereal disease transmission offences are still applicable in Western Australia<sup>20</sup> and in Tasmania.<sup>21</sup> In some jurisdictions transmission provisions relevant to HIV/AIDS will also apply to other sexually transmitted diseases.<sup>22</sup> The haste to criminalise the risk of HIV transmission ignores the failure of previous

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<sup>16</sup> Lewis, M., *Health and Disease in Australia: A History*, Canberra, Australian Government Publishing Service, 1989, at p. 269.

<sup>17</sup> Hall, R., 'Notifiable Diseases Surveillance, 1917-1991', *Communicable Diseases Intelligence*, 1993, 17/11:226-236.

<sup>18</sup> Report of the Director-General of Public Health, N.S.W., 1963-1967.

<sup>19</sup> documented by Daniels, K., *So Much Hard Work*, Sydney, Fontana, 1984. The position of prostitutes was similar in the United States (Brandt, A., A. M., *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*, New York, Oxford University Press, 1987); and, in England (Walkowitz, R., *Prostitution and Victorian Society: Women, Class and the State*, Cambridge, Cambridge University Press, 1980; Mort, F., *Dangerous Sexualities, Medico-moral politics in England since 1830*, London, Routledge and Kegan Paul, 1987).

<sup>20</sup> s. 310 *Health Act* (1911)(W.A.).

<sup>21</sup> s. 49 *Public Health Act* (1962)(Tas.).

<sup>22</sup> For example, s. 11 *Public Health Act* (1991)(N.S.W.) and s. 32A *Health Act* (1937)(Qld) as amended in 1988. These provisions are discussed *infra*.

attempts to control venereal disease. In fact, when venereal disease transmission or notification legislation has been enforced in the United States, there has been no discernible effect on the rate of transmission of such diseases.<sup>23</sup> Likewise in Australia, Commonwealth statistics reveal that there was a steep increase in notifications for gonococcal infection, syphilis and Hepatitis B in the mid-late 1970's and again in 1991.<sup>24</sup> It is uncertain whether these trends are merely reporting peculiarities prompted by swings in medical thought at particular periods. Admittedly, deterrence is hard to measure statistically but the US experience of venereal disease legislation at least would indirectly support the view that the mere existence of an HIV-specific transmission offence on the statute books may have little effect on the rates of infection.

The provisions which imposed penalties for transmission of venereal diseases were similarly worded in each State and Territory (with the exception of the Australian Capital Territory, where transmission of a venereal disease is not penalised under the *Venereal Disease Ordinance* (1956) renamed *Sexually Transmitted Diseases Act*). But in 1984 AIDS was added to the list of venereal diseases only in the States of New South Wales and Queensland.<sup>25</sup> This effectively meant that in these States, a person could be charged for transmitting HIV under provisions relating to epidemiologically different diseases.

Section 21 of the New South Wales *Venereal Diseases Act* (1918) read as follows:

No person shall knowingly infect any other person with a venereal disease or knowingly do or permit or suffer any act likely to lead to the infection of any other person with such a disease.

The provision was unusual in public health legislation. Generally regulatory offences created under statutes excluding Crimes Acts or *Criminal Codes*, such as public health or traffic legislation, will not specify a particular mental

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<sup>23</sup> Brandt, *supra* note 19, at p. 239. Endorsed also by Selvin, M., 'Changing Medical and Societal Attitudes Toward Sexually Transmitted Diseases: A Historical Overview', in Holmes, K. K., Mardh, P., Sparling, P. F., and Wiesner, P. J. (eds), *Sexually Transmitted Diseases*, New York, McGraw-Hill, 1990, 3-18, at p. 18 who suggests that statistical evidence shows a steady increase in the incidence of venereal disease throughout the world from the nineteenth century into the twentieth century.

<sup>24</sup> Hall, *supra* note 17, at 231-232.

<sup>25</sup> *Health Act* (1937)(Qld), s54; *Venereal Diseases Act* (1918).

element (*mens rea*) within the terms of the offence. The offence is then complete once the external elements (*actus reus*) have been proven.<sup>26</sup> There is a presumption at common law that *mens rea* is required to constitute any statutory offence. However, the presumption may be rebutted not only by the words of the statute creating the offence, but also by the nature of the subject matter with which it deals.<sup>27</sup> In 1985, a majority of the High Court of Australia in *He Kaw Teh v R*<sup>28</sup> held that the presumption of *mens rea* will not readily be displaced. Nevertheless, later courts have cited this case with approval but held that the statute in question imposed strict liability.<sup>29</sup>

Section 21 of the New South Wales provision was not a strict liability one given the inclusion of the terms 'knowingly' and 'permit'.<sup>30</sup> Hence the provision would have required that A knew his or her infected status and that the act engaged in was likely to lead to infection. By including the term 'knowingly' in the provision it would, in the AIDS context, encourage persons to avoid seeking testing which would confirm their HIV antibody status.<sup>31</sup> Under this provision it would also have been necessary to prove beyond reasonable doubt that A infected V, which is a part of the *actus reus*.

The *Venereal Diseases Act* (1918)(N.S.W.) did not specify the procedure to be adopted for dealing with transmission offences. However, section 19 of the same Act stated that where a matter was to be heard by a

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<sup>26</sup> Where a specific mental state is not required to be proven by the prosecution the offence is known as one of either strict liability or absolute liability. With a strict liability offence the defence of honest and reasonable mistake is open to A but is not with an absolute liability offence: Gillies, P., *Criminal Law*, 2nd ed, Sydney, Law Book Company, 1990, p. 103.

<sup>27</sup> *Sherras v De Rutzen* [1895] 1 QB 918. In *Sherras v De Rutzen* Wright J stated the following as exceptions to the rule:

1. acts "which are not criminal in any real sense, but are acts which in the public interest are prohibited under a penalty,"
2. public nuisances,
3. "cases in which although the proceeding is criminal in form, it is really only a summary mode of enforcing a civil right" (at p. 921-2). See also Lord Diplock in *Sweet v Parsley* [1970] AC 132 at p. 162. Approved of by the High Court of Australia in *Cameron v Holt* (1979) 54 ALJR 202 at 203.

Hence, where laws are made for the protection of the public health, safety or general welfare the presumption may be displaced.

<sup>28</sup> (1985) 59 ALJR 620.

<sup>29</sup> Asche J in *Chiou Yaou Fa v Morris* (1987) 46 NTR 1.

<sup>30</sup> Gillies, *supra* note 26, at p. 713 where he cites Lord Goddard in *Reynolds v G. J. Austin & Sons Ltd* [1952] 2 KB 135 at p. 147 citing *Somerset v Wade* [1894] 1 QB 574: "a man cannot be guilty of permitting that of which he does not know."

<sup>31</sup> Where an offence using the term 'permits' is construed as requiring *mens rea*, recklessness will be sufficient (Gillies, *supra* note 26, at p. 714).

Magistrate, proceedings would be in private. It is not clear whether a transmission offence would have been a matter to be heard by a Magistrate although presumably if the defendant pleaded not guilty it would be. Further, many of the provisions relating to venereal disease had no applicability to AIDS. For example, provisions that contain clauses 'when free from infection' have no applicability to a disease like AIDS where there is no cure. Hence, adding AIDS to the list of venereal diseases in the New South Wales legislation was a mis-guided response by the legislature.

Pre-AIDS public health statutes would be overinclusive with respect to HIV infection because they would penalise mere exposure where that behaviour is not likely to lead to the spread of the disease. Venereal disease statutes are underinclusive because HIV can be spread by means other than sex, for example, by needle-sharing or blood transfusions. In addition, the statutes ignore the fact that AIDS is a fatal and incurable disease. To impose only summary liability for transmission of a disease that will inevitably result in death could be viewed as too lenient. The problem lies simply in the fact that these statutes were not devised with AIDS in mind. The knowledge of this fuelled arguments towards the creation of an HIV-specific offence.

#### **4. CREATING A SPECIFIC HIV TRANSMISSION OFFENCE**

It has been stated earlier that historically in Australia there have been few reported prosecutions for the transmission of venereal disease despite the existence of a specific offence. This has also been the position in both the United Kingdom <sup>32</sup> and the United States. <sup>33</sup> This may have been due to two facts, the first that it was difficult to adduce supporting evidence from unwilling complainants and second that it was rare for the disease to be used in a threatening manner. Overall, it would be correct to suggest that there was some prosecutorial apathy in the public health sphere with respect to venereal diseases. By contrast, the advent of HIV has been accompanied by a flurry of amendments in the criminal law sphere in Australia and the United States reflecting an apparent interest in prosecuting transmission. Given that the problems of proof that were encountered with venereal disease

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<sup>32</sup> Catterall, R. D., and Nicol, C. S. (eds), *Sexually Transmitted Diseases*, London, Academic Press, 1976.

<sup>33</sup> Cutler, J. C. and Arnold, R. C., 'Venereal Disease Control by Health Departments in the Past: Lessons for the Present' *Am J Pub Health*, 1988, 78/4:372-376, at p. 372.

prosecutions will be likely to arise in the context of HIV, this recent policy is rather curious.

By contrast, in the United Kingdom a similar policy has not been adopted.<sup>34</sup> This reluctance in the United Kingdom, in England and Wales at least, may be fostered by the centralised system of government where public approval for legislative action may be difficult to obtain due to the large number of groups with pluralist ideas and values. In a federation, notwithstanding the fact that pluralist groups abound, populations within a State can be small and dispersed. In addition, a State can be characterised as adhering to a particular political persuasion. In such an environment public approval for legislative action could be gained in at least one State where the general ethos of the population is either conservative or liberal. This is more likely if the population rate is low. The continued reluctance of the Tasmanian State government to legalise homosexual conduct between consenting adults is testimony to this view.

Both criminal law and public health law claim responsibility for imposing penalties following HIV/AIDS transmission. This concurrent role is not unconstitutional as the States have powers to legislate in both areas, but it is the present writer's view that there are strong arguments that can be mounted as to why a specific HIV offence should be placed in one legal area or the other and not both. The question whether there needs to be a specific HIV offence requires a two-fold analysis in order to be answered. First it needs to be clarified why a specific transmission offence is required and whether it should be placed within either the criminal law or public health law. Second, it needs to be decided what the terms of such an offence will be.

#### THE NEED FOR AN HIV-SPECIFIC OFFENCE - A CRIMINAL LAW OR PUBLIC HEALTH CONCERN?

The first issue that needs to be addressed is why there needs to be a specific offence at all. Although they do not explain why they concluded as they did, the Intergovernmental Working Party on AIDS were against the creation of a specific offence. This was despite the fact that the Party was in

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<sup>34</sup> The Law Commission in their 1992-3 report on legislating for a new criminal code did not cover the issue of transmission of disease (Law Commission, *Legislating the Criminal Code: Offences Against the Person and General Principles*, Consultation Paper 122, London, HMSO, 1992 and Report No. 128, London, HMSO, 1993).

favour of the criminal law having application to the control of HIV/AIDS.<sup>35</sup> The arguments for and against a specific provision need to be considered.

The obvious argument in favour of a specific offence is the issue covered in previous chapters relating to the inappropriateness of applying pre-existing legislation. Both the criminal law and public health law are aligned on this point. Under public health law as well as criminal law, the evidentiary and causation problems as outlined in chapter three and this chapter and inherent in transmission of the virus would be difficult to overcome. A Sydney prostitute detained under section 32A of the *Public Health Act* (1902) (N.S.W.) in August 1989, who publicly admitted continuing to 'work the streets' after contracting AIDS<sup>36</sup>, was not prosecuted under section 50(N) of the *Public Health (Proclaimed Diseases) Amendment Act* (1985)(N.S.W.) (now known as s. 13(1) of the *Public Health Act* (1991)), which penalises a person engaging in sexual intercourse while infected with a proclaimed disease (which included AIDS and now HIV). This was despite the fact that in this particular case there was a clear admission of having penetrative sex with intention to transmit the virus. It is not clear why a prosecution was not laid. Perhaps there was no complainant. The New South Wales provision requires that the defendant be infected with HIV at the time of engaging in sexual intercourse. Since the provision does not require proof of infection in the victim, i.e. that transmission has been successful, then causation should be easily established providing that there is evidence that the accused was notified of a positive test result for HIV infection prior to sexual intercourse taking place. Hence, the enactment of a provision specific to HIV exclusively may potentially remedy some of the defects outlined earlier in this chapter and in chapter three.<sup>37</sup>

The second argument commonly advanced in favour of a specific offence pertains to symbolism. In chapter two the necessity for symbolic legislation in the context of the criminal law was canvassed. It was stated that often offences with a moral component are seen as worthy of

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<sup>35</sup> IGCA, *Legislative Approaches to Public Health Control of HIV Infection*, Canberra, Department of Community Services and Health, 1991, at p. 45.

<sup>36</sup> 'Prostitute with AIDS detained', *The Age*, August 1 1989, at p. 3 'AIDS Prostitute freed from prison', *The Age*, August 2 1989, at p. 3.

<sup>37</sup> Although the New South Wales statute was clearly enacted with HIV/AIDS in mind it is not truly specific to HIV infection and hence there is some lack of clarity. This point is covered later in this chapter under 'Post-AIDS Public Health Amendments' where the New South Wales statute is considered in some detail in conjunction with other State legislation on the topic.

criminalisation to set social standards as a symbol in order to have a deterrent effect. Whether or not a provision is merely to have a symbolic effect is an important question to be resolved as the motive behind any enactment will surely be relevant to the effort taken to clarify its terms.

The creation of an HIV-specific offence on the basis of its deterrent value may receive the support of some members of the community.<sup>38</sup> But, apart from the obvious argument that legislation is not a suitable instrument to convey an acceptable standard of morality, the so-called deterrent effect of punishment is difficult to test empirically. At least one commentator<sup>39</sup> believes that such an offence can only act as a deterrent if it is placed in the criminal law because otherwise people will not know of its existence. The implication here is that people are more likely to know about criminal penalties than public health ones. There is no evidence provided in support of his theory.

An HIV-specific criminal sanction in the criminal law context is likely to be superfluous depending upon who it is meant to apply to. For example, it would be unlikely to be invoked against someone who is suffering the debilitating effects of symptomatic AIDS. It may well be unlikely to deter those who know they are dying irrespective of their stage of infection. In addition, its existence in any sphere is debatable when one considers the evidence in Australia of behavioural changes occurring amongst homosexual men and prostitutes despite the creation of criminal offences relating to AIDS.<sup>40</sup> It is thought that education has been the catalyst for these behavioural changes rather the threat of public health penalties or the fact that existing

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<sup>38</sup> Smith, K. J. M., 'AIDS and the Criminal Law' (1991) 42(4) *Northern Ireland Legal Quarterly*, 309-331; Tierney, T. W., 'Criminalising the Sexual Transmission of HIV: An International Analysis' (1992) 15 *Hastings International and Comparative Law Review*, 475; Anon, 'The Politics of AIDS: Wilson Tuckey's Address' (1988) 2/8 *National AIDS Bulletin*, 45-47.

<sup>39</sup> Smith, *Ibid* at p. 329.

<sup>40</sup> See study by Harcourt, C., Philpot, C. R., and Edwards, J., 'Human Immunodeficiency Virus Infection in Prostitutes', *Med J Aust* 150, 1989, 150:540-541 and discussed in chapter two, footnote 3, and in relation to homosexual men in Guinan, J. J., Kronenberg, C., Gold, J., *et al*, 'Sexual behavioural change in partners of homosexual men infected with HIV', *Med J Aust*, 1988, 149:162; Ross, M., Herbert, P., 'Response of Homosexual men to AIDS', *Med J Aust*, 1987, 146:280; Commonwealth of Australia, *A time to care, a time to act: A strategy for all Australians*, Canberra, Australian Government Publishing Service, 1988, at pp. 67-69. The conclusion has been drawn in the latter articles that while an increasing number of homosexuals were engaging in safe-sexual practices, voluntary HIV antibody testing and counselling were listed as possibly being the only effective way to induce changes in sexual behaviour. These articles were written before the legislative amendments in both New South Wales and Victoria that took place in 1991 and 1993 which are discussed in chapter three.

criminal law provisions could be used to launch prosecutions. In fact, present proscriptions against homosexuals, prostitutes and drug users have been held to be responsible for driving those persons underground during the AIDS crisis.<sup>41</sup>

This leaves protagonists of HIV specific offences with their third argument relating to education. Here it is said that an HIV specific offence is needed for the purpose of promoting change. Smith,<sup>42</sup> then goes further and suggests that it is for this reason that such an offence should appear in the criminal law rather than in public health law. This point has some intuitive appeal but he offers it up as pure assertion without any empirical or theoretical support. In fact, this thesis has illustrated to the contrary that the law (particularly the criminal law) has a limited ability to lead and educate.<sup>43</sup> Using an HIV transmission offence as a teaching tool within the criminal law is likely to be no more successful than present drug prohibitions have been in educating people to stay off drugs. In addition, if the method behind criminalisation is to show people that HIV is an evil to be avoided this may not be justified if people already know that certain activities are in fact low-risk for transmission and, that campaigns divorced from the criminal law, for example, in the public health arena, have been instrumental in their current education.

If the State is to be given the right to prevent a person from acting it would need to be shown not only that the population were ignorant of the modes and risk of HIV transmission but that the risk was extreme and objectively unreasonable. If for example, people knew the risks but not the magnitude would that level of ignorance justify even a 'soft' paternalistic response? It would be near to impossible to claim that people are ignorant or at least find such a percentage of the population that were, to justify such a criminal law. By the same token, mere knowledge of a risk is not sufficient to show that persons assume it voluntarily. If a law could be drafted in such a way that its main purpose was to educate then there would be some use in placing it within public health legislation.

Finally, the issue of creating an HIV transmission offence cannot be considered in isolation of questions of administrative practicality. This is not to say that practical concerns should be paramount but they are of some

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<sup>41</sup> Commonwealth of Australia, *Ibid*, at pp. 69 and 125.

<sup>42</sup> Smith, *supra* note 38.

<sup>43</sup> The issue of deterrence was considered in detail in chapter two, pp. 61-67.



significance in deciding whether to place a penal provision in a statute book and gain respect for that law. Such a transmission offence even within the public health sphere would currently be unworkable because police (who would also have jurisdiction on behalf of public health officials) will find it difficult to detect cases and the presumption of innocence and burden of proof all count against transmission being proved in a causative sense in a majority of cases. However, in the public health sphere this may be remedied by the duties imposed on doctors to notify public health departments of cases and individuals who are endangering the public health. Police do not generally have access to details about individuals who are posing a risk in the community.

For the reasons discussed above and also in chapter two, if the aim behind enacting an HIV specific offence is not to punish or deter simpliciter but is to achieve behavioural change then this is a solid argument for asserting that public health law rather than criminal law would be the appropriate mechanism to bring it to fruition. If it can be shown that prevention by education is enhanced by the inclusion of such an offence then the present writer supports its establishment within the realm of public health. The establishment of an HIV-specific offence within the criminal law which covers a wide range of mental states may impede efforts towards further behaviour change and should be resisted. Further, it may add little to already existing offences.

#### WHAT SHOULD BE THE TERMS OF AN HIV-SPECIFIC OFFENCE?

If an HIV specific transmission offence was to be placed in public health law it is highly likely that the drafting of the provision would be problematic. There are many situations that surround an act of transmission. It would not be an easy task to create provisions that both penalise and seek to educate. It would also be difficult to draft penal provisions applying to HIV infection without allegations of discrimination arising. Laws that penalise transmission of the virus should not appear to discriminate against certain identifiable social groups. The creation of sexual offences with respect to HIV invites intrusion into the private lives of citizens particularly if they are homosexual or drug users. The US experience shows that the creation of specific offences does not preclude some groups being selected for

discriminatory treatment.<sup>44</sup> This has also occurred in Australia.<sup>45</sup> In reality, persecution will exist with or without an HIV-specific statutory provision being enacted given the fact that the groups afflicted with HIV infection are already marginalised in society.

It would be necessary to consider whether an HIV-specific offence should be one of strict liability. As noted earlier, many regulatory type offences do not require proof of a mental element to secure a conviction. In 1947, Starke J in *Poole v Wah Min Chan*<sup>46</sup> held that an Act of Parliament may prohibit an act in such a way as to make the prohibition absolute. However, the High Court in *He Kaw Teh*<sup>47</sup> sounded the death knell for such a stance by holding that it would be a rare situation where the presumption of *mens rea* would be displaced. Since the transmission of HIV results ultimately in death, the penalty should be severe and criminal principles applicable to public health regulatory type offences would require that *mens rea* be proven beyond reasonable doubt. To do otherwise would also represent a departure from previous practice with regard to criminalising the transmission of venereal diseases only upon proof of 'knowing' transmission. However, as Starke J suggests, such legislation commonly imposes penalties without requiring proof of *mens rea*.<sup>48</sup> There are examples from drug legislation, particularly drug trafficking offences, where legislatures are prepared to erode fundamental rights by in some cases by reversing the onus of proof and also imposing strict liability and high penalties.

A provision based on objective fact and not moral judgment and narrowly targeted on the most dangerous modes of transmission would be the most acceptable type to enact. Statutes must not be too broad based. An example would be a statute that criminalised transmission accompanied by a wide range of mental elements. The converse is the statute that is overinclusive in terms of conduct. For example, in the Commonwealth of Independent States (CIS) (formerly Soviet Union), under legislation passed in 1987,

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<sup>44</sup> For example, in the United States, many of the provisions that are HIV-specific, focus on prostitutes (Tierney, *supra* note 38, at fn 199).

<sup>45</sup> As discussed in the conclusion to chapter three, footnote 179 citing fn 174.

<sup>46</sup> (1947) 75 CLR 218.

<sup>47</sup> (1985) 59 ALJR 620.

<sup>48</sup> in *Poole v Wah Min Chan* (1947) 75 CLR 218, at p. 231.

any person who knowingly exposes another person to the risk of infection by AIDS shall be liable to deprivation of liberty of up to five years.<sup>49</sup>

Similar terminology appears in section 189 (as translated) of the Czech Republic (formerly Czechoslovakia) *Penal Code* (1961), which reads:

Any person who intentionally occasions or aggravates a danger of the introduction or spread of an infectious human disease [AIDS included] shall be liable to a sentence of up to three years imprisonment or to correctional measures.<sup>50</sup>

Chapter one has revealed that not every action is likely to transmit HIV. Many are very low risk for transmission. However, under these provisions such activities are criminal. Adding terms such as 'grave and unjustifiable risk of infection' encourage the need for definition and would lead to a debate about the degree of risk involved in some activities compared to others. Vague terminology such as the phrase 'intimate conduct' which appeared in the Illinois *Annotated Statutes* 1989 should be avoided.<sup>51</sup>

Carefully crafted laws could serve to ensure that liability is clearly delineated to protect both the victim and the accused. The elements of the offence need to be in a format that can be comprehended by both A, who is obliged to observe the law, and, where appropriate, by a jury empanelled to participate in the enforcement of the offence.

Such an offence would by its terminology need to ensure that the transmission of HIV should only be penalised if the person:

- (a) knows that he or she is HIV-infective and has been advised not to engage in unsafe sexual or needle-sharing activities,
- (b) does not notify his or her partner of his or her HIV antibody status or does not take precautions to prevent the exchange of infected bodily fluids, and

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<sup>49</sup> Paragraph 2 of Decree of 25 August 1987 of the Presidium of the USSR Supreme Soviet on measures for the prevention of infection by the AIDS virus (Izvestia, August 26 1987, p. 2) inserting new section 115 into the Penal Code of the RSFSR (1960) reproduced in WHO, *Legislative Responses to AIDS*, Dordrecht, Martinus Nijhoff Publishers, 1989, at p.193).

<sup>50</sup> Czech Socialist Republic Notice of 2 December 1987 of the Ministry of Justice of the Czech Socialist Republic establishing the list of communicable disease in main for the purposes of sections 189-190 of the Penal Code of 1961 (Sbirka zákonu Československa socialistická republika, December 16 1987, No. 23, Serial no. 104, at p. 574) reproduced by WHO, *Ibid*, at p. 43-44.

<sup>51</sup> § 12-16.2. Crim. 'Transmission of HIV', *Illinois Annotated Statutes*, ch. 111/21, para. 7306, 1989.

(c) engages in sexual penetration or needle sharing or engages in needle trauma (includes injecting infected syringe into another).

The penalty should reflect the fact of the gravity and incurability of HIV-infection.

Even these characteristics could be criticised on a number of grounds. For example, criterion (a) would encourage persons not to appear for testing. On the other hand, it could be argued that it is unjust to criminalise unknowing transmission. Criterion (a) reduces problems of proving that A was indeed infected at the time of the act said to transmit HIV to V although it does not solve the problem of ascertaining if V was already infected. Medical evidence could be called to document A's infected status. The ignorant would not be charged under the provision. Further, it does not call for inferences to be drawn that A should have known what would occur because he or she was a member of a high-risk group. The provision also places the onus on medical practitioners to advise an HIV-infected person to take precautions to prevent the infection being transmitted to others. Under this provision, the fact that there is a low probability of HIV being transmitted on one occasion is ignored. In reality, this provision penalises health endangerment which is a sound idea if it is to be placed in public health legislation.

The advantage in criterion (b) is that it encourages notification and honesty in relationships and educates the public as to the need for precautions to be adopted. By adopting safe sexual practices for HIV, protection would also be afforded against the transmission of other sexually transmitted diseases. The IGCA Working Party suggested that an insistence or agreement on use of safe sexual practices should be made a partial defence to transmission offences.<sup>52</sup> Community groups by contrast have argued that it be a complete defence. This is not appropriate as the risk of transmission should be known and consented to by both participating partners even if the risk is small, for example, if a condom breaks or lesions are present. Any defence of safe practices should depend upon who instigates the measures, a point which the Working Party did not consider. In the Working Party's view a full defence is available where a person consents to the risk of infection and understands both the nature and quality of the act. Although some people will accept the disclosure and act accordingly because they do not accept the risk to be great, the law in one sense would be

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<sup>52</sup> IGCA, *supra* note 35, at p. 47.

encouraging people to consent to death given the incurable nature of HIV infection.<sup>53</sup> Bronitt believes that a defence of protective measures is unnecessary because use of such measures would negate the intent required for committing the offence.<sup>54</sup> While true from a legal liability standpoint, one must bear in mind the purpose behind the establishment of the offence and the educative aspects to be gained.

Rather than to simply invalidate consent in all circumstances, it would be preferable to encourage or legally require the disclosure of HIV status between persons. This is in effect what the draft provision seeks to do. Such a requirement is less of an inroad on individual freedom than outright restrictions on consent. If a person is fully informed or has taken precautions to protect himself or herself against transmission of HIV when engaging in activities that are recognised as high-risk such as sexual intercourse and needle-sharing, then the risk could not be said to be extreme so as to warrant interference with his or her ability to consent. This 'softer' form of paternalism is likely to be more acceptable to the public. It has not been considered whether an individual should both fully inform his or her partner and take precautions when engaging in high-risk activity. Such a requirement might be expecting too much of some people leading them to neglect both and thus places others at risk. It is preferable to leave the choice open to people. It is understandable that some individuals would be more likely to use precautions than advise their prospective partners of their HIV status because they fear an irrational response from their partner.

Criterion (c) covers those activities medically documented as being most at risk for transmission of HIV. Hence not all sexual activities (such as oral sex) are covered. This keeps interference in sexual relationships to the minimum. Moreover, biting and spitting which are low risk for transmission of HIV would not be covered by the provision.

Under this proposal it would be unnecessary to prove an intent to harm or that HIV was actually transmitted. This does not mean that the offence is one of absolute liability. The provision requires actual knowledge on the part of A that he or she is infected. It also assumes that A knows what activities are likely to transmit HIV because he or she has been counselled

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<sup>53</sup> If such a defence were to be enacted in the criminal law sphere there would at least in Tasmania be some conflict with section 53 of the *Code*, which states that a person cannot consent to an injury likely to cause death.

<sup>54</sup> Bronitt, S., 'Criminal Liability for Transmission of HIV/AIDS' (1992) 16 *Criminal Law Journal*, 85-93, at p. 92. This point is not strictly relevant to the draft provision under discussion since there are no mental states prescribed.

after receiving the test result. The proposed offence is therefore more likely to be one of strict liability. As such the defence of honest and reasonable mistake would be open to A.<sup>55</sup>

Terms denoting the mental states of intention, recklessness and negligence are avoided. This means that these terms would not need to be defined within the statutory provision and any State or Territory differences in their interpretation (for example, the argument whether intention includes recklessness<sup>56</sup>) could be ignored. It could be argued that there is no reason why recklessness or negligence in the transmission of HIV should not be criminalised. In fact, it was suggested in chapter three, that these mental states will most commonly accompany HIV transmission. In addition, reckless or negligent acts are often treated by the criminal law as no less serious than intentional ones; but, in the case of HIV/AIDS they may be harder to prove than the deliberate and intentional wanton acts of aggression of, for example, the syringe bandit. Criminalising reckless or negligent transmission in the area of public health may provoke the use of safe precautions by infected persons and encourage disclosure to sexual partners. It is true that if negligence were to be a form of liability then the facts which would prevent liability and those which would need to be proven to incriminate a person, could be clearly set out. For example, to negate a finding of negligence a person could be required to show that he or she had obtained a negative test result prior to the offence and that precautions had been used. However, it is arguable that the draft provision covers this very situation without resorting to terminology which is apt to confuse.

Conversely, prosecuting the reckless or negligent transmission of HIV would affect a very large population. People might be held accountable not only for what they know, but also for what they reasonably should know, and there are potentially thousands of people who could be susceptible to criminal charges if this were the case. With respect to negligence, A could be held responsible even if he or she did not know he or she had HIV so long as a reasonable person in his or her circumstances should have known or should have taken steps to find out. It is more difficult to support liability in negligence which runs counter to the subjectivist nature of criminal law within Australia. Arguably the criminal stigma should be reserved for conscious wrongdoers. The fact that negligence which is objectively based on community standards

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<sup>55</sup> *supra* note 26.

<sup>56</sup> discussed in chapter three (pp. 89-94) where the mental states of intention and recklessness are considered in the crime of Murder.

is omitted from the proposed statutory provision would mean that juries would not have the final decision on what A should have known. Some members of the jury could have irrational views embedded in their minds by the hysteria that has surrounded HIV/AIDS.

## 5. POST-AIDS PUBLIC HEALTH LEGISLATION

As noted earlier in this chapter, it may have been the recognition fostered by particular lobby groups and the various governmental AIDS Committees,<sup>57</sup> of the shortcomings of the pre-AIDS public health statutes, that led some legislatures to devise a new offence dealing with transmission of infectious diseases. Amendments to many statutes resulted in repealing former venereal disease legislation and rewriting much of the former communicable disease provisions in public health statutes.

It also brought to the attention of legislators and those within public health departments the opportunities for the exercise of investigatory and prosecutorial prejudice provided by the former venereal diseases legislation which has in the past affected certain groups, such as prostitutes. However, in light of this the initial legislative response was not acceptable. Although HIV/AIDS was taken out of the realm of venereal disease, focus was again placed on the activities of minority groups. During the reign of syphilis in the nineteenth century these provisions had been enforced against women and particularly 'fallen women' or prostitutes.<sup>58</sup> With the so-called AIDS amendments governments through their public health policies again allowed women as prostitutes and male homosexuals to be singled out as the sources of infection.<sup>59</sup> IV drug users were also focused on but by the police who were using their powers under drug misuse legislation. It has been argued by some that this is an 'unavoidable discriminatory consequence of the present distribution pattern of infection'.<sup>60</sup> While true to some extent there is no need for this to be manifested in prosecutorial policy which places education of heterosexuals at risk. Such a policy merely supported what has always been asserted, that only the highly visible will be selected by law enforcement

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<sup>57</sup> Commonwealth of Australia, *supra* note 41.

<sup>58</sup> Daniels, *supra* note 19; Brandt, *supra* note 19; Parmet, W. E., 'AIDS and Quarantine: A Revival of an Archaic Doctrine' (1985) 14 *Hofstra Law Review*, 53-90.

<sup>59</sup> as the case of 'Charlene', illustrates, *supra* note 36 and is discussed in chapter five.

<sup>60</sup> Smith, *supra* note 38.

officials who cannot enter the bedrooms of the nation. In the middle to late 1980s one would not have been mistaken for thinking that Australia's public health policy had not advanced far from that existing in the nineteenth century except that there was one important difference. Instead of women being marginalised as with the venereal disease policy of the two Wars which was aimed at prostitutes exclusively, in addition, AIDS saw the marginalisation of other social minorities: homosexuals and IV drug users.

An examination of the legislation would support these views. In the middle to late 1980s Queensland, New South Wales, South Australia and Victoria passed new public health legislation that created an offence for a person to transmit HIV to another person. The provisions were not directly AIDS-specific offences but could be said to have been highly motivated by AIDS. The interpretation provisions in the Acts have been amended and government proclamations have been passed to include AIDS or HIV infection (in various stages) as infectious diseases for the purpose of the provisions.

The passage of the Queensland and New South Wales legislation may be perceived as a political move to calm community responses in the early days of the epidemic. The resulting legislation has been condemned as an example of ill-considered action by governments.<sup>61</sup> The enactment has been criticised as exemplifying the reluctance of politicians to accept unanimous advice from experienced professionals that legislation may not be a panacea for society's ills.<sup>62</sup> In 1993 Tasmania passed legislation also covering this area. The legislation from each of the States will be examined separately in order to focus on the breadth of the provision and whether it corresponds adequately to the ideal legislative provision set out in an earlier section of this chapter.

## QUEENSLAND

The Queensland *Health Act Amendment Act (No. 2)* (1984) followed the 1984 'baby transfusion cases'. Three babies died after birth from

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<sup>61</sup> Altman, D., *AIDS in the Minds of America*, New York, Anchor Press/Doubleday, 1986, at p.185. He refers to the sensationalism by the press as it appears in 'States Move on AIDS Peril', *Sydney Morning Herald*, November 17 1984, and Yvonne Preston, 'The AIDS Panic: a Modern-Day Witch-hunt', *Sydney Morning Herald*, December 10 1984.

<sup>62</sup> See Carr, A., 'AIDS: The Australian Response', *Meeting the Challenge*, Canberra, Australian Government Publishing Service, 1986, 50-55, Kirby, M., *Ineffective and Unjust Laws*, unpublished abstract, 1987 and Dwyer, J. M., 'Legislating AIDS Away', *Med J Aust* 1985, 143:276-277. McGuirl, M. C., Gee, R. N., 'AIDS: An Overview of the British, Australian and American Responses' (1985) 14 *Hofstra Law Review*, 107-135.



receiving transfusions of blood donated by an infected carrier. Altman describes the pandemonium that erupted in Queensland as a "modern-day witch hunt", in which the conservative party of that state 'insinuated that gays were deliberately setting out to contaminate others with "bad blood"'.<sup>63</sup>

Section 3(a) of the *Health Act Amendment Act (No. 2)* (1984) added AIDS to the list of venereal diseases for the purpose of section 54 of the Health Act (1937). Subsections 3 (f)-(i) of the Act imposed a penalty of \$10,000 or 2 years imprisonment or both on any person who knowingly infected any other with AIDS unless, at the time the infection was transmitted, the infected person was the spouse or connubial of the first-mentioned person, knew about the condition of the infected person and voluntarily ran the risk of being infected. Therefore A would not be able to rely on a defence if the virus was transmitted to V even if A disclosed his or her infected status to V unless A was married to or a de facto of V. Although the provision may be viewed as having a realistic application in the sense that it is rare for HIV to be contracted through one contact with the infected agent, it could also be argued that the provision is ill-conceived because it appears to encourage honesty between persons only involved in more permanent relationships. This section could also have applied to the transmission of HIV through needle sharing, as a particular mode of transmission was not specified.

In 1988, the *Health Act Amendment Act* was passed which technically repealed these provisions and removed AIDS from the list of venereal diseases. This was timely because adding AIDS to the list of venereal diseases gave moral connotation to the disease, and ignored the fact that the virus could be spread by other means. The 1988 legislation did re-enact some of the old provisions but with different definitions guiding interpretation. For example, under the 1988 Act AIDS is regarded as a 'controlled notifiable disease'. Section 48 repeated section 3 (f)-(i) of the old 1984 Act, except it had application to other 'controlled notifiable diseases'.

This Queensland provision only penalised the person transmitting the infection upon proof of infection. In addition, the section was couched in terms of knowingly infecting another person, not knowingly creating a risk of infection. The former would require that the infection be transmitted whereas the latter would not. Under the former the accused must know that AIDS will be transmitted. The fact that the legislature did not frame the offence in terms of the full range of risk-creating conduct with respect to the

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<sup>63</sup> Altman, *supra* note 61, at p. 185.

transmission of HIV is very likely to be taken to indicate that there must be at least a high probability of transmitting AIDS and the accused knew this, before the offence will be committed. This means there will be many cases where conviction for knowingly infecting will not be possible, whereas it would have been if the provision had imposed liability where A engages in conduct at risk of transmitting AIDS. It is preferable for the provision to have an educative function; it should seek to prevent people placing others at risk of infection.

The 1988 provision was defective because medically one cannot transmit AIDS. Only HIV infection can be transmitted.<sup>64</sup> Therefore, the offence of knowingly infecting another with AIDS was medically impossible to commit and could have resulted in charges against an accused person being dismissed. In 1993, the provision was amended by providing two alternative heads of liability. Under the amendments, 'a person must not deliberately or recklessly put someone else at risk of infection from a "controlled notifiable disease" ' (s. 48(2)) or 'must not deliberately or recklessly infect someone with a controlled notifiable disease' (s. 48(2)(A)). The defect with respect to AIDS and HIV terminology has also been corrected.

### NEW SOUTH WALES

Under section 50(N) of the *Public Health (Proclaimed Diseases) Amendment Act* (1985), which has been reproduced in amended terms as section 13(1) of the *Public Health Act* (1991), it was an offence to have sexual intercourse (which is not defined) with another person,

if that person knows he suffers from a  
sexually transmissible medical condition  
unless before sexual intercourse takes place,  
the other person has,

(a) been informed of the risk of contracting a  
proclaimed disease from the person with  
whom sexual intercourse is proposed, and,

(b) voluntarily agreed to accept that risk.

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<sup>64</sup> This problem has been an ongoing one in the criminal justice arena. It can be seen in the judgments in *US v Moore* (USDC D Minn. No. Crim 4-87-44 and on appeal 846 F 2d 1163 (8th Cir. 1988)) fuelling the hysteria that AIDS itself can be transmitted rather than HIV. In Australia in 1993 a sentencing judgment set down the importance of the difference implying that there is some level of judicial ignorance on the point (*R v Dowlett* unreported judgment NSW Court of Criminal Appeal, 6 July 1993).

For the purposes of this section a 'sexually transmitted medical condition' <sup>65</sup> is defined to include AIDS and HIV.

Section 50(N) was criticised as likely to drive HIV sufferers underground instead of presenting themselves to clinics for treatment, advice or counselling. <sup>66</sup> In addition, section 50(N) came into effect at a time when medical knowledge about the virus, its modes of transmission and methods of prevention, were inconclusive. The legislation was passed prior to April 1985 when blood screening procedures were first implemented at blood facilities in Australia. Hence, the legislation became underinclusive as more scientific knowledge was acquired, particularly that HIV could be transmitted also by needle sharing. It is an excellent example of the problems that may arise when legislators pass legislation ahead of professional knowledge. Although the New South Wales provision does specifically deal with assumption of risk, the section fails to deal adequately with question of what should be encompassed within an informed consent.

Unlike the original Queensland legislation, section 50N of the New South Wales Act, focuses specifically on sexual intercourse as a mode of transmission, to the exclusion of any other mode. For example, an IV drug user infecting another through the use of shared needles would not be covered by the legislation. This may lend weight to the argument that this legislation, like that in Queensland, was aimed primarily at homosexual activity, although the section would clearly penalise heterosexual intercourse also. Acts of injecting another with an infected syringe may be the least problematic in terms of proof. This is especially so where the victim has no other high-risk practices, the act is deliberate and there are witnesses to the act. This lacuna in public health legislation may be one reason why a prosecution under criminal legislation for attempted murder was laid in the case involving a prison warder in a New South Wales prison who was wounded by an inmate with a syringe containing HIV contaminated blood. <sup>67</sup>

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<sup>65</sup> Under r. 34D *Public Health Regulations* (1960)(N.S.W.) as amended in 1985 a 'proclaimed disease' to which the section formerly referred included AIDS, Lymphadenopathy syndrome or the condition of having, or having antibodies to, the AIDS virus.

<sup>66</sup> The authors are outlined in note 61.

<sup>67</sup> 'AIDS jab may bring murder attempt count', *The Mercury*, July 23 1990, p. 1 and 'AIDS stabbing case in-court', *The Mercury*, August 7 1990. See also chapter three, footnote 115.

## VICTORIA

In May 1990 the *Health (General Amendment) Act* (1988) came into operation amending the *Health Act* (1958) and providing penalties for recklessly transmitting infectious diseases (including HIV/AIDS). The legislation is prefaced with a set of principles that 'apply for the purposes of the application, operation and interpretation of the legislation'.<sup>68</sup> The main thrust behind the principles is that-

[T]he spread of infectious diseases should be prevented or limited without imposing unnecessary restrictions on personal liberty or privacy.<sup>69</sup>

Under section 120(1) of the Act it is an offence punishable by a fine of \$20,000 (200 penalty units) for a person to knowingly or recklessly infect another person with an infectious disease. Section 120(2) provides a defence where 'the person infected with the infectious disease knew of and voluntarily accepted the risk of being infected with that infectious disease'. Again, this section punishes only upon proof of infection. The section raises the issue of the level of risk required for recklessness to be established. If decided in accordance with the criminal law then only significant risks would be covered.<sup>70</sup> In addition, when read in conjunction with section 119(c) which imposes a duty on a person who suspects that he or she is infected to ascertain whether or not he or she is infected, it might be questioned whether wilful blindness as to the possibility of being HIV-positive would constitute recklessness in the public health sphere. With careful jury direction, this should not occur given that recklessness applies to the resulting injury rather than to a collateral factor.

## SOUTH AUSTRALIA

In South Australia, under section 37(1) of the *Public and Environmental Health Act* (1987), a person suffering from a 'controlled notifiable disease' shall take all reasonable measures to prevent transmission of the disease to others. A controlled notifiable disease initially included AIDS

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<sup>68</sup> s. 119(a)-(e).

<sup>69</sup> s. 119(a). 'Victoria's New AIDS Legislation' (1988) *National AIDS Bulletin*, April, 6-7.

<sup>70</sup> as set out in chapter three.

and AIDS Related Complex but since 1993 it includes AIDS and HIV only.<sup>71</sup> The maximum penalty for transmission is \$30,000 or seven years imprisonment. No guidelines are provided to assist in interpreting the term reasonable measures and whether persons who unknowingly transmit HIV would be penalised. There is also no guidance on matters of consent. However, this may be the only provision of the four debated that draws a differentiation between the use of safe and unsafe sexual practices, by inclusion of the phrase 'reasonable measures'.

It may also be argued that, unlike the Queensland, New South Wales and Victorian provisions, the South Australian provision sets up either an absolute or strict liability offence where *mens rea* is either irrelevant or only partially relevant to the charge. However, given the severity of the penalty to be imposed it is submitted that at the very least this is the type of statute that would allow either evidence of honest and reasonable mistake to be pleaded, or the presumption of *mens rea* will apply, requiring some mental state on behalf of A to be proven.

## TASMANIA

In 1993 after a period of long parliamentary and community debate<sup>72</sup> the *HIV/AIDS Preventative Measures Act* was proclaimed. The Tasmanian legislature had ample time to consider carefully the appropriate tenor of the provisions that it was drafting. The State legislature is to be commended for focusing legislative intervention specifically for transmission only in the public health sphere. Two of the other jurisdictions (New South Wales and Victoria) have overlapping criminal law and public health provisions. It is questionable whether such a specific and lengthy document dealing solely with HIV/AIDS was necessary in a State where infections are reportedly low. In fact, it can be queried whether it should include other sexually transmitted diseases, although these are arguably covered under transmission provisions relating to venereal diseases in the 1962 *Public Health Act*.

Section 20(1) of the 1993 Act which focuses on transmission of HIV begins by setting out an educative provision. It specified that a person

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<sup>71</sup> In the Schedule to the *Public and Environmental Health (Review) Amendment Act* (1993).

<sup>72</sup> The *HIV/AIDS Preventative Measures Bill* was drafted in 1990 and introduced into Parliament the same year. It was rejected by the Upper House, the Tasmanian Legislative Assembly and had to be reformulated and re-introduced during 1992.

who is aware of being infected with HIV must '(a) take all reasonable measures and precautions to prevent the transmission of HIV to others; and (b) inform in advance any sexual contact or person with whom needles are shared of that fact'. (underlining emphasis added). This double requirement (as underlined) imposed on the infected person marks a divergence from the draft provision set out in this chapter (at p.153) where it was suggested that one requirement was sufficient. Section 20(2) specifies that such a person must not knowingly or recklessly place another person at risk of becoming infected with HIV unless that other person knew that fact and voluntarily accepted the risk of being infected. Although the inclusion of mental states has been criticised in this thesis, the provision at least does not include negligence. From the layout of the section it is clear that the educative aspects are foremost rather than the penalty. This view is supported by section 21 (2)(a) which clearly establishes that a person will only be subject to a penalty if counselling and restrictions on lifestyle such as isolation fail to produce a more responsible attitude towards engaging in behaviour that might place others at risk of transmission of HIV.

Sub-section (3) of section 20 ensures that a person receives:

- (a) adequate information and education about the transmission of HIV; and,
- (b) adequate counselling under s. 15; and,
- (c) appropriate medical and psychological assessment; and,
- (d) a letter from the Secretary warning that criminal liability attaches to behaviour which may constitute an offence under subsection (2).

it is unclear what the legal effect might be if the accused has not received this information. Does it mean that the accused has a possible defence when engaging in conduct prohibited by section 20(2) when he or she is not provided with the information? By the inclusion of this provision, the legislature appears to be sharing the onus of responsibility for transmission of the disease on health professionals, the public health department and the infected person. This is a novel approach to curbing the spread of the epidemic. Such an approach would appear to be at odds with the 1993-6 *National HIV/AIDS Strategy* <sup>73</sup> which suggests that each person must accept responsibility for preventing themselves from becoming infected. The present writer views the focus on individual responsibility in the Strategy as

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<sup>73</sup> Commonwealth of Australia, 1993-4 -1995-6 *National HIV/AIDS Strategy*, Canberra, Australian Government Publishing Service, 1993, at p. 10.

misguided. The socio-economic and environmental forces which have shaped this disease means that taking responsibility for preventing the spread of the disease without assistance from authorities is difficult for some members of society. Although the Tasmanian provision represents a move toward a more enlightened policy in this regard, it must be noted that the educative aspects of the Tasmanian legislation may be impeded by two facts. The first being that homosexual activity is still illegal in that State and second, that the *HIV/AIDS Preventative Measures Act* prevents the promotion of same sex conduct including the promotion of safe-sexual measures.

### SUMMARY OF POST-AIDS TRANSMISSION STATUTES

The fact that most of the transmission offences under public health legislation are technically not HIV-specific (with the exception of Tasmania), means that the causation and evidential problems that were considered when focusing on the application of traditional criminal law principles may arise again. However, specificity may not necessarily eradicate this problem. For example, all the public health statutes including the Tasmanian provision do not address how it could be conclusively proven that A passed the virus to V.<sup>74</sup> Many questions could arise with respect to consent. For example, would a victim be permitted to consent to HIV infection under these public health statutes given that under criminal law principles a victim cannot consent to death? <sup>75</sup> In Tasmania it is apparent that provided a person has been informed of HIV infection in the partner then his or her consent is valid. In most of the other public health provisions it appears that the issue is side-stepped by allowing V to consent to the 'risk of' infection and not death. But, it may be unrealistic to think of consenting to a risk of infection when in reality, given the fatal nature of AIDS one is really consenting to the risk of death. On the other hand, if consent were not a defence then an infected party has less of an incentive to disclose his or her condition.

There are also questions with respect to A's knowledge. Would A be guilty if, suspecting he or she had HIV/AIDS, undertook an antibody test, received a false negative or was tested during the 'window period' and

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<sup>74</sup> In chapter two at footnote 6 reference was made to the fact that procedures are being developed which will permit a particular strain of the virus to be identified thus removing some doubts over establishing causation in HIV related criminal cases (Pantaleo, G., Graziosi, C., Fauci, A.S., 'The Immunopathogenesis of HIV infection' *New Eng J Med*, (1993) 328:327-335).

<sup>75</sup> This issue was discussed in chapter three, footnote 49 and text.

engaged in sexual intercourse on the faith of that false negative test result? As a matter of evidence the answer should surely be no. But, as this testing period is notoriously unreliable, there is arguably a duty on A to be retested or at least to abstain from any high-risk activity until his or her antibody negative status can be confirmed. The Tasmanian legislation does not address this fully merely by limiting liability for transmission to any person 'who is and is aware of being infected with HIV or is carrying and is aware of carrying HIV antibodies ...' (s. 20 (1)(2)). Under that provision, it may be questioned whether the term 'aware of' incorporates 'suspicion'? If 'aware of' only equals knowledge then if A receives an antibody negative result this would clearly be evidence A could rely on. However, if 'aware of' includes 'suspicion', then if A has engaged in activity that A knows has placed him or her at high-risk for being infected with the virus then A could be subject to liability irrespective of the false negative result. Suspicion rather than knowledge would render an increased number of the population open to prosecution for what they should have known rather than for what they did know.

However, the Queensland, New South Wales, Victorian and Tasmanian provisions specifically require knowledge as a form of *mens rea*. This factor could lead to the additional problem where an individual deliberately refrains from obtaining a test result on the ground that, once he or she does so, his or her antibody status will be known and he or she will be more likely to be convicted under the provision. As stated above, where knowledge is a requirement to be proven, the fact that a person was a member of a high risk group might be evidence from which a jury might infer that he or she knew they might communicate HIV. Whether this point is valid may depend on whether a form of constructive knowledge rather than actual knowledge would be sufficient for liability under provisions where the terminology is used. This concern might be why the Victorian provision also penalises reckless transmission. However, by including recklessness the legislation casts a very wide net. It is more likely that HIV will be transmitted in circumstances of recklessness than conscious desire. But, the existence of a penalty for reckless transmission may make people more responsible in the conduct of sexual or needle-sharing activity.

Overall, despite some criticisms, the theme underlying the Queensland, New South Wales, Victorian and South Australian and especially the Tasmanian public health transmission legislation is in accord with twentieth century society. First, the legislation does not endorse a 'total-abstinence' policy. It is likely that such a policy would fail as it has in the past



with respect to prostitution, homosexuality and drug use. Conversely, it does not support a 'totally-permissive' approach leaving the decision whether or not to engage in conduct that will spread the virus to the relevant parties. Instead, the legislatures have attempted to provide incentives for sexual partners and IV needle sharers to honestly disclose their condition and to use precautions. Public health departments are now entrusted with the task of developing a culture of responsibility. There is room for improvement in the drafting of such obligations in some of the States. The statutes reveal an attempt to educate. At the same time they also communicate to society that the legislatures condemn the knowing spread of infectious diseases and thus the statutes may have some deterrent value if that is considered necessary. It is arguably sound legislative practice to avoid specificity in imposing penalties, leaving it to the courts to develop precedents and relying on their adherence to the maxim that penal provisions are construed narrowly.<sup>76</sup>

The passage of the AIDS-related public health legislation reveals that politics is very important in public health. It is in fact its cornerstone. To view it as apolitical that would be to mask the play of social forces appropriately called forth in the making of decisions affecting the communal welfare.

The debates culminating in the Tasmanian legislation highlights the difficulty of policy formation concurring sexuality in a complex society. The reason why the passage of the legislation took so long in Tasmania was that even as the government supported what was widely seen as a repressive measure, it had to specifically to exclude information about AIDS from its provision. The new policy assumed the need to promote sex education as the only way of halting the threatened epidemic. Implicitly, that meant the co-operation and involvement of the community most at risk, the gay community, a policy that was anathema to the ideologies behind the conservative project in Tasmania. It is significant that the legislation contains section 22 which penalises the promotion of certain sexual activities (implying homosexual conduct). Apart from this provision the thrust of the legislation is as its title suggests - preventative rather than punitive. The simple reason is that the

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<sup>76</sup> However, courts feeling bound by a separation of powers have not always illustrated a willingness to be creative judicially so as to effect a change in the law. The whole issue of passive versus active law-making in the courts is beyond the scope of this thesis. It is possible to point to at least one instance in the criminal law where Judges have stated that it is for Parliament to effect changes to the law if it felt it were necessary rather than courts. In Tasmania, see for example, Cox J in *Palmer* an unreported judgment of the Supreme Court of Tasmania 1985, at p. 3 and more recently in *Brown v DPP* [1993] 2 WLR 556 per Mustill LJ (at p. 600) and Slynn LJ (at p. 608).

legislature knew that there was no practical alternative that would achieve widespread acceptability. The boundaries between acceptable and unacceptable sexual behaviour remained fluid and indeterminate and homosexuality remained ambiguously on the margins of social life, its acceptability still in doubt. There is no doubt that the Tasmanian government has been constrained by its moral agenda and overall this may operate to reduce the overall effectiveness of the provision.

## 6. CONCLUSION

Public health offences occupy a territory between full criminal status and civil proceedings. The intervention of public health to control disease is long-standing and in general, except for instances of discrimination in earlier periods, has a respectable history. The criminalisation of medical problems is problematic insofar as it is based on a control model that seeks to individualise social problems. Placing HIV/AIDS in the public health sphere should reduce the individualisation of the problem and render it one which requires community responsibility.

The foregoing analysis of public health provisions reveals that like criminal penalty provisions they do not fit the circumstances of HIV/AIDS infection neatly. Admittedly, some of these provisions were developed in a different era of infectious diseases, those characterised by acute periods of transmissibility. Hence they are generally inappropriate to AIDS, especially when they impose periods of detention until 'free from infection'. The legislation carry very light penalties for what is, in reality, the transmission of a deadly virus and rarely contain provisions preventing breaches of confidentiality during prosecutions. Although there have been some amendments, provisions in public health statutes in Australia also contain inherent evidentiary and causation concerns which are problematic when applied to HIV-infection.

Post-AIDS public health amendments have attempted to modify the law taking into account these basic deficiencies but uniformity between Australian jurisdictions is lacking. The legislation, with the exception of Tasmania, does not specify whether an infected person prosecuted for a transmission offence might be isolated and if so where. Provision for reasonable treatment, detention and counselling of such persons must be available if public health departments are to have responsibility for this

disease. In addition, all legislatures need to address concerns such as the possibility of vexatious complaints.

Although piecemeal amendments have been made to existing public health legislation, with the advent of so many vocal community groups, further refinements are likely to be a cumbersome process involving community debate. The long debates culminating in the delayed passage of parts of the Tasmanian *HIV/AIDS Preventative Measures Act* (1993) would support this viewpoint. The creation of a comprehensive HIV-specific public health transmission offence is preferable as it may remedy these deficiencies, but such a provision should only seek to penalise highly dangerous behaviour. A draft offence was formulated in this chapter. It carried forward the theme of seeking to change the behaviour of people who are infected with HIV by requiring them to give certain information and take certain precautions before engaging in well-defined dangerous activities. To gain public support and respect such a provision must be drafted in a tone that least interferes with personal lives. It must also be recognised that a provision such as that drafted in this chapter would be unlikely to find favour with the vast number of lobby groups. For example, church groups might be opposed to the inclusion of any defence based on condom use given their stand on contraception. Others might object to the implicit recognition of drug use which is illegal. Rather than debate the terms of such a comprehensive and specific offence, legislatures (especially those in Western Australia and the Northern Territory where amendments are long overdue) would be wiser to spend time remedying some of the defects of pre-existing public health legislation. The aim should be to repeal archaic provisions and enact ones that would apply equally to other life-threatening diseases.

The theme behind curbing the spread of HIV/AIDS should be the prevention of the risk of infection. Therefore, responsibility for imposing penalties upon individuals who place others at risk of infection by their behaviour should primarily lie with the public health instrumentalities. Public health departments are provided with widely based powers which enable officials and their agents to detain and isolate persons suspected of transmitting communicable diseases or exposing others to risk of infection. These powers warrant examination in order to finally conclude whether locating responsibility for transmission of HIV within the public health sphere is a meaningful choice from the point of view of an HIV-infected person and society. These powers and public health procedures will be analysed in the next chapter.

## CHAPTER 5

### **PUBLIC HEALTH OFFICIALS' POWERS IN CONTROLLING THE SPREAD OF AIDS**

#### **1. INTRODUCTION**

This thesis has argued that control of individuals with respect to the transmission of HIV should primarily be a public health concern. Criminal sanctions or pre-existing criminal laws should be used for prosecuting only that behaviour with appropriately high culpability. Statutes grant to public health officials jurisdiction over individuals who exhibit or may be likely to engage in conduct that might facilitate transmission of a communicable disease to another or place others at risk of such transmission. Public health departments are more appropriately placed than criminal law agencies to ascertain risk levels as their ethos is prospective rather than retrospective.

Irrespective of the arguments for and against the use of the criminal law in the context of AIDS, it is primarily in the area of public health that legal measures have been introduced. The detention of a prostitute in a Sydney hospital in August 1989 under section 32A of the *Public Health Act* (1902) (N.S.W.)<sup>1</sup>, brought to the forefront the difficulties confronting Australian public health departments in implementing either AIDS-specific legislation or existing legislation relevant to communicable diseases. The prostitute, who publicly admitted she continued to 'work the streets' for at least three years after contracting HIV, was detained for six days in a hospital in that State under section 32A as a last resort procedure, after persistent attempts to persuade the prostitute to behave responsibly had been ignored.<sup>2</sup>

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<sup>1</sup> 'Prostitute with AIDS detained', *The Age*, August 1 1989, at p. 3. 'AIDS Prostitute freed from prison', *The Age*, August 2 1989, at p. 3. The *Public Health Act* (1902) was replaced in part by the *Public Health Act* (1991) which was proclaimed in November 1991. This legislation continued the changes made by the *Public Health (Proclaimed Diseases Amendment) Act* (1989) proclaimed in May 1990 which in fact addressed many of the grievances with respect to section 32A case.

<sup>2</sup> Editorial, 'AIDS and Civil Rights', *The Age*, August 5-6 1989. Charlene has reportedly re-offended, in March 1991 ('TV show, new arrest in AIDS Prostitute Saga', *West Australian*, March 28 1991, at p. 27).

## Under Section 32A(1)

A medical officer of health or a legally qualified medical practitioner ... may... direct that [a] person ... (being a person suffering from an infectious disease) be removed to the hospital named in [an] order (being a hospital available for the reception and treatment of persons suffering from the infectious disease) ...

Section 32A(2)(a) of the *Public Health Act* (which is now repealed) also enabled health authorities to make such an order in respect of a person suffering from an infectious disease in the interests of public health.

The case of the Sydney prostitute received widespread media coverage and provoked much criticism. This was the first reported occasion in Australia of a person infected with HIV being forcibly detained in a hospital under that Act, although the provision existed before the advent of the 'AIDS crisis'. Civil Liberties groups argued that the detention was a fundamental breach of civil liberties as the detainee had no right of appeal under the legislation and no means of testing the department's decision through an independent tribunal.<sup>3</sup>

The case is important because it highlighted a central dilemma in the AIDS debate: how to balance the claim of the community to be protected against the disease and the claim of the individual not to be unfairly restricted. Public health legislation that enables officials to apply coercive measures that restrict the lives of persons suffering from infectious diseases was drawn to the public's attention by the media. Such legislation is in force in each State or Territory<sup>4</sup>, and means that the detention such as that which occurred in New South Wales could conceivably occur in any other Australian jurisdiction.<sup>5</sup> The legislation in New South Wales has been amended primarily in response to the case<sup>6</sup> but similar unamended provisions are still applicable in some Australian jurisdictions.

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<sup>3</sup> 'Prostitute with AIDS detained', *The Age*, August 1 1989, at p. 3.

<sup>4</sup> These provisions will be dealt with in more detail later in this chapter.

<sup>5</sup> Since the section 32A case detention has been threatened or implemented by public health departments in other States. In 1991 in Perth an HIV-infected person was placed under house arrest after threatening others with infection of HIV (Personal correspondence, Health Department, Perth WA). The Victorian Health Department warned that the last stage before isolation is a warning letter from the general manager of the Health Department. ('Vic Threat to isolate 11 AIDS carriers', *The Age*, September 11 1989.)

<sup>6</sup> Perkins, R., Lovejoy, F., and Marina, 'Protecting the community prostitutes and public health legislation in the age of AIDS', (1990) *Criminology Australia*, October/November, 6-8.

Interesting questions are raised by the detention of the Sydney prostitute. For example, what is the content of the power that public health departments have, to protect members of the community from infectious diseases? What measures can be used to protect the community from HIV-infected persons who admit or imply they have knowingly infected others? Does the implementation of such measures restrict the liberty and privacy of HIV-infected persons? Are such restrictions justified in the interests of community health? Will such restrictions result in long-term behavioural changes?

This chapter will review and analyse public health legislation currently in force in Australian States and Territories, discuss the potential for coercive strategies to be applied to AIDS sufferers and persons who are or who are presumed to be antibody-positive, and examine if, and if so how, the powers of the public health official or public health departments have been adapted in light of the emergence of HIV.

## **2. THE CONTENT OF COERCIVE POWERS OF PUBLIC HEALTH DEPARTMENTS**

Over the years public health authorities have been given certain powers to control communicable diseases. Nineteenth and twentieth century public health policies have included quarantine and/or isolation, compulsory vaccination, notification, orders for treatment and x-rays.

An examination of the efficacy of measures implemented to control the spread of communicable diseases in the past will be invaluable in the drafting of legislation and guidelines with a view to controlling the spread of HIV in the 1990s. There may be much that can be learnt about the ideology and politics of particular governments towards disease control from their use of coercive measures. The historical use of such measures will be examined together, where available, with the incidence of the imposition of penalties for a failure to heed orders issued under such legislation.

### REQUIREMENT OF NOTIFICATION

Early public health legislation in all States of Australia required the notification of the epidemic type diseases. Sexually transmitted diseases (STDs) were also notifiable under venereal disease legislation. This policy of

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notification has continued into the twentieth century. For example, plague, cholera, yellow fever and tuberculosis (TB) are still notifiable under State and Territory legislation in Australia.<sup>7</sup> With the exception of NSW, South Australia and Victoria, smallpox is still a notifiable disease.<sup>8</sup> Syphilis, hepatitis B and herpes<sup>9</sup> are some of the STDs that are notifiable diseases in Australia.

In the past, the sexually transmitted diseases have been provided for in legislation relating solely to venereal diseases. However, because these STDs were notifiable, persons suffering from them could be subjected to a number of legal restrictions contained in public health legislation. Such provisions potentially allowed officials to order persons to present for examination, to undergo treatment, to name contacts and imposed penalties on the failure to abide by orders.<sup>10</sup> Following the advent of HIV, many venereal disease statutes were repealed and STD's are now covered under general communicable diseases legislation.

In each Australian State and Territory, legislation exists which includes HIV infection in various stages up to and including AIDS as a notifiable disease. Medical practitioners are required to notify Health Departments of the identity of persons carrying HIV or reasonably suspected of carrying it. The legal classification of the conditions requiring notification differ in the various States and Territories, resulting in a lack of consistency and medical accuracy. For example, in South Australia although AIDS was notifiable from 1987, HIV infection was not notifiable until September 1991 whereas in Tasmania since 1989 the legislation has stated that 'all stages of AIDS' (which technically includes HIV) are notifiable.<sup>11</sup>

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<sup>7</sup> Department of Health, Housing and Community Services *Communicable Diseases Intelligence Bulletin*, 1992, 1: at p. 18 provides lists of currently notifiable diseases in Australia. Plague is not notifiable in Tasmania.

<sup>8</sup> Smallpox is not listed as a notifiable medical condition under s. 14 and Schedule 1 of the Public Health Act (1991)(N.S.W.) nor under the Schedules to the *Public and Environmental Health (Review) Amendment Act* (1993)(S.A.), nor as a notifiable disease under the *Health (Infectious Diseases) Regulations* (1990)(Vic.).

<sup>9</sup> *Communicable Diseases Intelligence Bulletin*, 1992, 1:18 per syphilis and hepatitis B. Herpes is not notifiable in every State.

<sup>10</sup> The provisions will be discussed in depth later in this chapter.

<sup>11</sup> **NSW:** In 1986, the *Public Health Regulations* (1960) were amended by the insertion of regulation 34D "Proclaimed Diseases". Under this regulation and for the purposes of section 50H of the *Public Health (Proclaimed Diseases) Amendment* (1985)(N.S.W.), medical practitioners must notify cases of AIDS or lymphadenopathy syndrome or the condition of having, or of having antibodies to, the AIDS virus as soon as practicable after they become aware or acquire reasonable grounds for believing a patient is suffering from any of these conditions. However, section 14 of the *Public Health Act* (1991) set out that category 5 'medical conditions' (defined in Schedule 1 to include AIDS and HIV infection), are notifiable.

Penalties may be imposed with a view to coercing doctors into notifying health departments of known or suspected cases of HIV infection in the community. Some States and Territories extend the requirement of notification. For example, under both the *Notifiable Diseases Act* (1981)(N.T.) and the *Health Act Amendment Act* (1988) (Qld.), persons other than doctors who fail to provide information about another person from whom

**VIC:** Under the *Diseases Notification Regulations* (1984) AIDS, ARC and lymphadenopathy syndrome were notifiable if a medical practitioner became aware the person was suffering from those diseases (r. 3). Under the *Health (Infectious Diseases) Regulations* (1990)(Vic.) AIDS (defined in accordance with the Centre for Disease Control surveillance 'case definition' of 1987) is notifiable under reg. 7 if a medical practitioner becomes aware that a person shows evidence of, has died of, or is a carrier of, the disease.

**QLD:** In July 1983, the Queensland Government Gazette 76 declared AIDS to be a notifiable disease under the *Health Act* (1937). AIDS is now referred to as a controlled notifiable disease following the proclamation of the *Health Act Amendment Act* (1988)(Qld.). Section 32 of the Act requires medical practitioners to notify the Director-General of Health if they believe a patient to be suffering from or to have symptoms of AIDS. HIV infection does not appear to be notifiable under this Act.

**WA:** Under an Order in Council of 1983, AIDS was declared a dangerous and infectious disease for which medical practitioners must notify the Health Department. Under the *Health-Dangerous Infectious Diseases Order* (1985)(W.A.) ARC, lymphadenopathy syndrome and HTLV-III infection are infectious and dangerous diseases for which medical practitioners must notify the Health Department. In February 1993 AIDS and HIV were added to the list of infectious diseases under the *Health Infectious Diseases Order*. S. 276(1)(c) of the *Health Act* (1911) states if a doctor suspects a person is suffering from an infectious disease Health Authorities must be notified.

**S.A.:** Under the *Public and Environmental Health Act* (1987)(S.A.) AIDS and ARC are notifiable diseases under Schedule 1. Section 30 requires medical practitioners aware that a person is suffering from a notifiable disease to report the existence of the disease to the Health Commission. HIV infection simpliciter became notifiable in September 1991 following an amendment to the *Public and Environmental Health (Notifiable Diseases) Regulations* (1989)(S.A.).

**TAS:** Under the *Public Health Act* (1962)(Tas.) AIDS was proclaimed an infectious and notifiable disease by Statutory Rule 151/1983. Statutory Rule 152/1983 added AIDS to the list of notifiable disease in Part 11 of Schedule 3 to the *Public Health (Notifiable Diseases) Regulations* (1967). Regulation 3(2) provides that a medical practitioner who is a superintendent or in charge of a hospital or other institution must notify the Director of Health of AIDS cases. In 1989, 'all stages of HIV infection' were added to the list of infectious and notifiable diseases in the Regulations for which a private practitioner must notify the Director of when he or she becomes aware or suspects a person is infected (*Public Health (Notifiable Diseases) Regulations* (1989) r. 4(1)).

**ACT:** The *Public Health (Infectious and Notifiable Diseases) Regulations* (1980)(A.C.T.) were amended by Regulation 10/1983 adding AIDS to the list of notifiable diseases and requiring notification where a medical practitioner has reason to believe that a person may be suffering from a notifiable disease (reg. 4). In 1992 HIV was added to the list of notifiable diseases.

**N.T.:** Under the *Notifiable Diseases Act* (1981)(N.T.) AIDS has been a notifiable disease since July 1983 (Schedule 3). S. 8 requires medical practitioners to notify authorities of persons who are infected or suspected or being infected. In 1988 HIV infection Groups 1-4 were declared notifiable diseases.



the disease may be contracted may also be liable to a penalty. In the Northern Territory a person has a statutory obligation to consider his or her HIV antibody status. Section 7 of the *Notifiable Diseases Act* states that a person must consult a doctor if he or she has reasonable grounds to believe that he or she is infected.

A historical analysis of TB notifications reveals that penalties have been imposed for failures to notify cases to authorities. Compulsory notification for TB in Australia began as early as 1909 in Tasmania.<sup>12</sup> In 1912 in that State two convictions were recorded for non-notification.<sup>13</sup> By 1913 Purdy, Secretary for Public Health reported that the increase in notifications was due to fines being imposed.<sup>14</sup> However, failure to notify has been most marked with respect to the STDs although there is little evidence that penalties have been implemented with respect to STDs.<sup>15</sup>

Compulsory notification legislation has not been challenged in Australia, although it has been in the United States in pre-AIDS cases. The case of *Whalen v Roe*<sup>16</sup> is authority in that country for the principle that legislation mandating notification is constitutional if the information obtained is reasonably related to a valid public health purpose; the information is limited to public health departments; and adequate statutory confidentiality protections are in place. A similar view could be taken by a court in Australia if the matter arose, although the lack of constitutional protections would

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<sup>12</sup> *Public Health Annual Reports*, Hobart, Health Department of Tasmania, 1909.

<sup>13</sup> *Public Health Annual Reports*, 1912, per Purdy, Secretary for Public Health, at p. 4.

<sup>14</sup> *Public Health Annual Reports*, 1913, at p. 4. Comstock, G. W., 'Tuberculosis', in Last, J. M. (ed), *Public Health and Preventive Medicine*, 12th ed, Connecticut, Appelton-Century-Crofts, 1986, 222-233.

<sup>15</sup> Chase, A., *The Truth About STD's*, New York, Quill, 1983, at p. 20-24. Forsyth, J. R. L., and Connors, J., 'A survey of Sexually Transmitted Disease Presenting to General Practitioners in Victoria', Abstract of Public Lecture presented at Combined Australian and New Zealand Scientific Conference on the Sexually Transmitted Diseases, August 1988 and reported in (1988) *Venereology*, 1:27. Communicable Diseases Section, Community Health and Services, 'Notifications of Sexually Transmitted Diseases in Victoria Annual Report 1988' *Communicable Diseases Intelligence Bulletin*, 1989, 25: 6-13.

<sup>16</sup> 429 US 589 (1977). Prior to *Whalen*, there may have been cause to question whether legislation mandating notification was constitutional given that it may have contradicted the right of privacy and liberty provisions of the US Constitution. Although not explicitly enumerated in the Bill of Rights, the right of privacy is thought to arise from the penumbra of the first, ninth and fourteenth amendments. It is said in the United States that this gives in effect a 'right' of privacy but only against State and individuals acting on behalf of the state - not against individuals or non-government entities. The case of *Roe v Wade* had expressed the view that the 'right of privacy' was founded in the 14th amendment 'concept of personal liberty and restrictions upon state action' or in the 9th amendment reservation of rights to the people' (93 S Ct. 705, 35 L Ed. 2d. 147 (1973) at pp. 152-153).

preclude any decision from focusing on the constitutionality of the issue. The issue of divulging confidential information in the interests of public health is considered later in this chapter.

### COMPULSORY EXAMINATION, ISOLATION AND QUARANTINE ORDERS

Pre-existing public health legislation in the various Australian States and Territories empowers officials to require infectious persons to undergo medical examinations and be the subjects of isolation and quarantine orders. These measures are the most coercive available. South Australia, New South Wales, Victoria, Queensland and Tasmania have passed specific legislation applying this form of control to HIV-infected persons.<sup>17</sup> In the remaining States and Territories, existing and antiquated public health and venereal disease legislation traditionally applying to infectious sexually and non-sexually transmitted diseases will, following the extension of the terms 'infectious' or 'notifiable' to include AIDS or HIV, apply to HIV-infected persons. These particular measures and the legislation implementing such measures warrant examination.

#### (i) Compulsory Examination and Testing

Compulsory examination and testing legislation has been enacted to curb the spread of communicable diseases in Australian States. It was most commonly applied to TB sufferers. For example, a Federally-funded, but State-managed campaign of compulsory chest x-rays has been a feature of controlling the incidence of TB in all Australian jurisdictions.<sup>18</sup>

In Tasmania, for example, chest clinics were established in Hobart in 1936. Other Australian States followed suit. In 1938, in Tasmania, 31 orders were served on persons failing to present for treatment after receiving a positive x-ray.<sup>19</sup> By 1942, the Tasmanian Public Health Department

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<sup>17</sup> The relevant legislation is: *Public Health (Proclaimed Diseases) Amendment Act* (1985)(N.S.W.) which was followed by the *Public Health Act* (1991)(N.S.W.); *Public and Environmental Health Act* (1987)(S.A.); *Health (General Amendment) (Amendment) Act* (1989)(Vic.); *Health Act Amendment Act* (1988)(Qld.), *HIV/AIDS Preventative Measures Act* (1993).

<sup>18</sup> Dawson, D., 'Tuberculosis in Australia: an unfinished fight' *Med J Aust.*, 1991, 154:75-76, at p. 75

<sup>19</sup> Brothers, C., Medical Superintendent, *Public Health Annual Reports*, 1938.

began considering the implementation of mass x-rays on the population.<sup>20</sup> Mass x-rays commenced in 1945. By 1947 the value of mass x-rays in detecting cases was already being heralded. The Public Health Reports at that time called for the compulsory examination of all persons over fourteen years of age.<sup>21</sup>

Annual compulsory chest x-rays applicable to certain age-groups began in 1949 following the passage of the *Tuberculosis Act* (1949)(Tas.) and continued until 1977 when Federal funding was withdrawn and States carried on their own programmes dependent on need.<sup>22</sup> Failure to present for the x-rays carried the threat of the imposition of a fine or a period of imprisonment. Both the 1950 and 1956 *Annual Public Health Reports* state that it was believed that the efficacy of continuous screening was responsible for a drop in TB cases.<sup>23</sup> The *Annual Report for Health* (Cth) for 1959-60 identified that whereas deaths from TB amounted to 29.6% of all deaths recorded for 1947, the death-rate from TB infection had dropped to 5.48% of all deaths in 1959.<sup>24</sup>

The very existence of mass screening for TB has lead at least one commentator to advocate the introduction of compulsory HIV antibody testing to curb the spread of HIV.<sup>25</sup> However, the efficacy of mass chest x-rays for TB has been questioned.<sup>26</sup> The problem areas included the difficulty of distinguishing between active and inactive TB, distinguishing TB from other diseases of a similar nature and the possibility of reading errors. This factor, combined with high administrative costs, may have been the reason why

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<sup>20</sup> *Public Health Annual Reports*, 1942, at p. 5.

<sup>21</sup> *Public Health Annual Reports*, 1947, at p. 17 per Director of TB, Goddard, T. H.

<sup>22</sup> Tasmanian Government Gazette, Vols. 1949-1977. The power to order compulsory radiological examinations of persons over fourteen years was in accordance with section 5 of the *Tuberculosis Act* (1949)(Tas) (and as amended 1963). See also Dawson, *supra* note 18, at p. 75.

<sup>23</sup> Goddard, T. H., Secretary of Health, *Public Health Annual Reports*, 1950, at p. 31 and Tremayne, Director of TB, in *Public Health Annual Reports*, 1956, at p. 40.

<sup>24</sup> *Report of Director-General of Health*, Commonwealth Department of Health, 1959-1960, at p. 7.

<sup>25</sup> As exemplified from the speech of Wilson Tuckey to delegates of Third National Conference on AIDS, in 'The Politics of AIDS: Wilson Tuckey's Address' (1988) 2/8 *National AIDS Bulletin*, 45-47.

<sup>26</sup> See Locks, M. O. in 'Tuberculosis', in Wherle, P. F., and Top, F. H., (eds), *Communicable and Infectious Diseases*, 9th ed, St Louis, C.V. Mosby Company, 1981, 670-730, at pp. 686-688 and Comstock, G. W., 'Tuberculosis', in Last, *supra* note 14, 222-233, at pp. 227-228. But, a contrary view is provided by Burnet, M. and White, D. O., *Natural History of Infectious Diseases*, 4th ed, London, Cambridge University Press, 1972, at pp. 222-223.

compulsory chest x-rays were phased out in the late 1970s in Australia. Alternatively mass screening may have been phased out because it had successfully controlled the incidence of TB by that time. Certainly statistics from Tasmania would support the latter hypothesis. For example by 1965 there were only 81 cases of TB notified. The year before there had been 105.

<sup>27</sup>

It is also arguable that improvements in sanitation and the development of sanatoria for the treatment of infected persons rather than compulsory chest x-rays may have significantly reduced TB rates in Australia. Sanatoria were set up in Australia between 1900-1910 but, as Lewis states, the coincidence in the emergence of sanatoria and the fall in the death-rate from TB should be noted but not overstated.<sup>28</sup> Further, it is possible that declines were due in large part to a general improvement in the economic and social welfare of countries. Researchers into the resurgence of TB in the United States in the 1990s have found sufferers in general to be a product of homelessness and poverty which directly supports the economic and social cause thesis.<sup>29</sup> The use of drug chemotherapy programmes was also influential.<sup>30</sup> Therefore, restrictive measures such as compulsory chest x-rays may not have been necessary to deal with the spread of TB. When viewed together, these factors reveal that there is no conclusive precedent in Australia set for compulsory HIV antibody testing as the means to curb the spread of HIV infection.

In Australia, prosecutions have been laid for failing to comply with treatment orders with respect to TB. In Tasmania, for example, in 1954, two persons were prosecuted for failing to comply with section 6 of the *Tuberculosis Act*. (1949).<sup>31</sup> This section provided that the Minister could order a person to undergo, within a certain period, a radiological/medical examination. Section 11 prescribed a penalty for failure to comply with the order. At that time Tremayne, the Director of TB, noted that it was difficult to

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<sup>27</sup> *Public Health Annual Reports*, 1965, at p. 25.

<sup>28</sup> Lewis, M., (ed.) *Health and Disease in Australia: A History*, Canberra, Australian Government Publishing Service, 1989, at p. 289.

<sup>29</sup> CDC, 'Tuberculosis Control Laws - United States, 1993', *MMWR*, 1993 42(No. RR-15):1 at p. 1.

<sup>30</sup> Porter, J.D.H., McAdam, K.P.W.J., (eds), *Tuberculosis: Back to the Future*, Chichester, Wiley and Sons, 1994, at p. 19-20.

<sup>31</sup> *Public Health Annual Reports*, 1954, at p. 41.

apply the compulsory provisions of the Act in the case of persons who were suspected of having TB. He urged amendments be made to the Act to strengthen the hand of the Director. This was not achieved.<sup>32</sup> Again in 1955 concern was expressed that a person had escaped prosecution for failing to comply with an order in 1954, because the Crown had not proved wilful disobedience.<sup>33</sup> It was felt that further prosecutions could be hampered if an amendment were not made to the Act.<sup>34</sup> No amendments in that respect were made.

In 1963 in Tasmania a new *Tuberculosis Act* was passed. Both the 1949 and 1963 Acts provide in section 10 (s. 11: 1963) that the person against whom a detention or treatment order or decision is made has the right to appeal to a Judge in chambers against the order or decision. This legislation is more progressive than the *Public Health Act* (1962) in Tasmania of the preceding year, under which there is no right of appeal for persons who are the subjects of compulsory detention or examination orders and are suffering from diseases other than TB.

Many of the compulsory testing or examination provisions in public health legislation have their roots in the early 19th century and focused on venereal diseases. For example, during the 1870s prostitutes were singled out for compulsory treatment for venereal disease. Two Australian colonies now known as Queensland and Tasmania introduced *Contagious Diseases* legislation that was applied purely to prostitutes. The Acts were repealed in 1911 and 1903 respectively due to opposition from the population notably females because officials failed to detect a sufficient number of cases and when they did so often many women were found to be non-infectious.<sup>35</sup> There was also no centre where women could be detained and treated free of charge.

Compulsory treatment provisions for persons suffering from venereal diseases resurfaced in each State during the period from 1915 -

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<sup>32</sup> *Public Health Annual Reports*, 1954, at p. 41.

<sup>33</sup> *Tremayne v Cook* [1955] Tas SR 100. The court held that the prosecution needed to show 'not only that the direction to appear was disobeyed in fact but that the failure to obey was a deliberate and intentional act of a culpable nature' (at p. 102). A failure to appear due to oversight, honest mistake or circumstances preventing his appearance is not wilful and not an offence. His Honour believed that where no explanation was forthcoming from a defendant the jury could draw an inference of intent, but the inference must be safely drawn.

<sup>34</sup> *Public Health Annual Reports*, 1955, at p. 42.

<sup>35</sup> Daniels, K., *So Much Hard Work*, Sydney, Fontana, 1984, 64-68.

1937 under specific venereal disease legislation. By World War 1 venereal disease was rife among Australian soldiers. Fuelled by a request from the Commonwealth government, Western Australia began the move by passing the *Health Act Amendment Act* (1915) compelling treatment of all infected citizens.<sup>36</sup> Failure to submit resulted in the imposition of either a fine or imprisonment. When schemes were found to have little influence on the rates the Commonwealth Government passed the *National Security (Venereal Disease and Contraceptive) Regulations* (1946) which gave the power to the Commissioner of Venereal Diseases to detain for treatment anyone suspected of suffering from venereal disease.<sup>37</sup> There is no clear record of prosecutions under either the State or Commonwealth legislation during either of these periods. However, in the late 1950s and early 1960s an intense prosecutorial policy was mounted in New South Wales, in particular, against treatment defaulters. In 1957, 484 prosecutions were laid which increased to 642 in 1962.<sup>38</sup> There is no statistical breakdown available of the status of the individuals. This would be fairly useful given that the impetus for increased prosecutions appears to have been instigated following the receipt of a commissioned report which indicated that four groups were to blame for the increases: adolescents, immigrants, prostitutes and homosexuals.<sup>39</sup>

Public health officials in States and Territories without AIDS-specific legislation could rely on pre-existing public health provisions which apply to infectious or venereal diseases, if AIDS or HIV has been added to that list, to require persons suspected to be infected with HIV to undergo medical examinations. For example, in Western Australia, section 251(5) of the *Health Act* (1911) provides that once a person is suffering from an infectious disease he or she can be ordered to submit to a medical examination and the taking of medical samples. In the Australian Capital Territory, regulation 5 of the *Public Health (Infectious and Notifiable Diseases) Regulations* (1980) authorises the medical examination of a person suffering from a notifiable disease. Likewise, section 18 of the

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<sup>36</sup> Lewis, *supra* note 28, at p. 263. Other colonies followed suit with legislation being introduced in Victoria (1916), Tasmania and Queensland (1917), New South Wales, (1918) and South Australia (1920).

<sup>37</sup> Lewis, *Ibid*, at p. 270.

<sup>38</sup> Report of the Director General of Public Health, NSW, 1953-1957, 1963-1967.

<sup>39</sup> Lewis, M., 'From Blue Light Clinic to Nightingale Centre: A Brief History of the Sydney STD Centre and its Forerunners, Part 2: From the Postwar Years to the Present', *Venereology*, 1988, 1/2:45-49 at p. 45.

*Notifiable Diseases Act* (1981) in the Northern Territory allows persons suffering from notifiable diseases to be medically examined.

Amendments motivated by HIV/AIDS have been made in many States. In New South Wales, section 22 of the *Public Health Act* (1991) (formerly s. 50P of the *Public Health (Proclaimed Diseases) Amendment* (1985)) empower the Chief Health Officer of the Health Department to order compulsory medical examinations where he or she reasonably believes a person to be suffering from a category 5 'medical condition', which includes HIV/AIDS.

Likewise section 31 of the South Australian *Public and Environmental Health Act* (1987) grants the South Australian Health Commission the power to require a person reasonably suspected to be suffering from a notifiable disease (defined as AIDS or HIV) to present himself or herself for a medical examination (s. 31). Failure to comply with the notice renders a person liable to arrest upon the issue of a warrant from a Magistrate. Section 31(4) prohibits the detention of a person for more than forty-eight hours for the purpose of examination.

Under section 36(1) of the *Health Act Amendment Act* (1988)(Qld.) a person suffering from a 'controlled notifiable disease', who refuses to submit to any reasonable examination, test or treatment, may be removed to a public hospital or temporary isolation place and detained there until necessary examinations are conducted. Section 36(5) allows persons in charge of a public hospital or temporary isolation place to exercise such force as is reasonably necessary for the purpose of performing the examinations. A detained person who resists or obstructs any reasonable procedure being carried out commits an offence against the Act for which a summary penalty could be imposed.

None of the provisions considered above define the term 'medical examination' or describe what would be included in the term 'medical sample'. More than likely a 'medical examination' would include those procedures that were considered part of reasonable public health practice. However, there are no reported cases in which such legislation has been directly considered. It is unlikely that HIV testing would be included in that term unless it is specifically included, given the potential legal ramifications of such testing, including actionable breaches of confidentiality. The doctrine of informed consent to medical treatment <sup>40</sup> would be relevant to this debate as recognised in the

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<sup>40</sup> The doctrine and the issue of what is encompassed by the phrase 'medical examination' is considered in more detail in chapter six, pp. 242-245.

*National HIV/AIDS Strategy 1993-1996*. The Strategy clearly states that 'specific informed consent is to be obtained before any test is performed to diagnose a person's HIV infection status'.<sup>41</sup> It needs to be recognised however, that the strategy is merely a collection of guidelines which do not have the force of law.

Under section 121(1) of the Victorian *Health (General Amendment) (Amendment) Act* (1989), if the Chief General Manager of the Health Department reasonably believes that a person has an infectious disease including AIDS, and is likely to transmit that to a person who does not voluntarily accept the risk of being infected, he or she may require that the person be examined and tested for the disease or undergo counselling. Section 121(12) entitles an enforcement officer to arrest the subject of an order who will not comply. This would authorise the police to act on behalf of the Health Department by arresting and detaining an HIV-infected person. Section 121 (1) also grants a specific power to test for HIV which is not granted in the other State and Territory provisions.

The Tasmanian *HIV/AIDS Preventative Measures Act* proclaimed in June 1993 is the only legislation to be enacted in Australia which comprehensively provides for the public health administration of HIV/AIDS and could be said to be truly AIDS-specific. The 1993 legislation is supplemental to the *Public Health Act* (1962) in that State. Under section 17(1)(e) of the *Public Health Act* (1962) the Minister of Health could make an order that a person suffering from an infectious disease should 'submit themselves for a medical examination ...' Again that phrase was not defined and it is significant that the 1993 legislation (which is more likely to override the 1962 Act when an HIV-infected person is the subject of any compulsory order) specifies when an HIV test may be ordered. The fact that this legislation does make specific provision for HIV testing in another section of the Act is grounds for arguing in Tasmania, at least, that the term 'medical examination' does not include taking HIV tests as of right.

The Act authorises HIV testing in circumstances where the Secretary of Health has reasonable grounds to believe that an HIV-infected person is behaving in such a way as to place other persons at risk of being infected and is likely to continue to behave in such a way (s. 10(3)). The legislation may be criticised because it does not provide any guidance on how the 'risk' is to be determined. The only protection against abuse is provided if

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<sup>41</sup> Commonwealth of Australia, *National HIV/AIDS Strategy 1993-1994, 1995-1996*, Canberra, Australian Government Publishing Service, 1993, at p. 10.



by chance the infected person refuses to submit to testing and an application for testing is made under s. 11 of the Act to a Magistrate. In such an application the Secretary of Health must satisfy the requirement that there is evidence that 'other persons are or have been exposed to the possibility of transmission of HIV' (s. 11(3)(a)) and 'that it is in the interests of public health to make the order' (11(4)). Both the Victorian and Tasmanian legislation indicate that 1990s legislatures are aware that pre-existing legislation which contains broadly based terminology such as 'medical examination' would not be likely to hold up to a judicial challenge if someone is tested for HIV without his or her consent.

## (ii) Isolation or Quarantine

Public health legislation usually distinguishes between quarantine and isolation in provisions which grant powers to public health officials. Modern legislation tends to focus on using the terms isolation or detention rather than quarantine, a trend which may have developed to counter the stigma and fear historically attached to the latter practice. Quarantine is reserved as a general federal power under the *Constitution* (1900)(Cth) whereas the power to isolate is vested in public health officials under State public health legislation. While both concepts generally involve the segregation and separation of infected persons or things from the rest of the community their application is to different periods of the disease cycle. Quarantine usually refers to holding the person at a certain time because although he or she has been exposed to a disease it is unknown whether he or she is infected. It therefore covers the 'incubation period' of an illness which is problematic when considering HIV infection where the length of the incubation period is uncertain. Isolation usually refers to the practice of holding persons who are known to be infected until they can no longer infect others. Isolating an HIV-infected person in this manner would be draconian because once the virus has been transmitted he or she will never pass into a non-infectious stage.<sup>42</sup>

General legislation concerning quarantine of persons suffering from communicable diseases was first enacted in two Australian colonies during the smallpox epidemic of 1881-1882.<sup>43</sup> In 1908, the Commonwealth

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<sup>42</sup> Most of the modern legislation places a time limit on isolation. In the context of AIDS, for example, in s. 21(2)(c) of the *HIV/AIDS Preventative Measures Act* (1993)(Tas.) the time limit is 28 days.

<sup>43</sup> New South Wales *Quarantine Act* (1832) and Tasmanian *Quarantine Act* (1881).

government also passed a *Quarantine Act* under which a 'quarantinable disease' was defined to include, smallpox, plague, cholera, yellow fever or any disease declared to be a 'quarantinable disease'.<sup>44</sup> This meant both federal and State governments had concurrent powers over quarantine. In practice, federal powers were used in general to control shipping or in conjunction with immigration legislation. It was also applicable in those States where there was no legislation dealing with quarantine *per se*. There were never any challenges to the federal exercise of the power by the States. Federal quarantine officers at all ports of entry have since the enactment of the legislation exercised powers to detect cases of disease on entry to Australia. Responsibility for local cases and outbreaks have been handled initially by State public health departments.

The period marked by the smallpox epidemic in the late 1880s is regarded as one of the worst in Australian history in terms of suspending civil rights in the interests of public health. Persons were either detained in their homes or forcibly removed to quarantine stations. The Chinese, were rarely given the choice of staying in their home and bore the brunt of xenophobia and discriminatory action from authorities. Both the Tasmanian and Western Australian governments declared all Chinese ports infected areas and quarantined all ships arriving from those ports.<sup>45</sup>

Many persons quarantined were incorrectly diagnosed as suffering from smallpox when in reality they suffered from chicken-pox. Lack of knowledge of the epidemiology of smallpox led to persons being quarantined who were suspected of having made contact with an infected person. This in turn led to a witch hunt and false reporting. Panic was said to be fuelled by 'the primitive nature of colonial administrative structures and procedures for protecting community health.'<sup>46</sup> In fact, the outbreak of smallpox in Sydney occurred at a time when the colony of New South Wales had no general Health Act, no public health policy and no infectious diseases hospital. Other

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<sup>44</sup> s. 5. In 1984 the *Quarantine Amendment (Cth)* (1984) omitted smallpox as a 'quarantinable disease' under the Act. Quarantine may still be imposed on persons infected with TB who refuse to undergo a medical examination to detect the presence of pulmonary TB (s. 35AA *Quarantine Act* (1908)).

<sup>45</sup> These measures were implemented following the passage of the *Chinese Restriction Act* (1882)(Tas.). The Western Australian legislation is contained in *Act for the Restriction of Chinese Immigration* (1899).

<sup>46</sup> Mayne, A., 'The dreadful scourge: responses to smallpox in Sydney and Melbourne, 1881-2', in McCleod, R., and Lewis, M. (eds), *Disease, Medicine and Empire*, London, Routledge, 1988, 219-241, at p. 224.

colonies were in a similar position. Wisdom was drawn from overseas experience. The fact that smallpox was seen as a disease of the poor or one of filth may be a reason why public health legislation in the 1980s and 1990s carried over from earlier times focuses heavily on sanitation and inspection of premises.

The cholera epidemic illustrated that quarantine was ineffective, because of the ability of asymptomatic or mildly infectious carriers to enter and subsist in a population. As a result, during the cholera epidemic quarantine did not appear to have any significant effect on curbing the spread of disease.<sup>47</sup> As cholera is not spread by human contact it is questionable that human quarantine should have ever been imposed.

Although quarantine orders were reportedly not challenged in Australia, in the United States quarantines imposed for diseases such as smallpox, TB and cholera were, in general, upheld as valid.<sup>48</sup> In *Crayton v Larrabie*<sup>49</sup> the court revealed the overwhelming view at that time that the object of preservation of public health was all important. The court stated '... powers conferred for so greatly needed and most useful purposes, should receive a liberal construction for the advancement of the ends for which they were bestowed'.<sup>50</sup> In another example, the court suggested that 'neither the right to liberty nor right of property extend to the use of liberty or property to the injury of others'.<sup>51</sup> US courts generally refused to prevent arbitrary or unreasonable conduct of health officers in detaining persons. The courts upheld quarantine orders when the individual was not yet contagious on the basis that they need not wait until a carrier had made someone ill. For example, in *Crayton v Larrabie* the individual who was quarantined merely lived next door to someone with smallpox. This procedure was followed again during World War II when prostitutes were detained until they could be examined for venereal disease.

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<sup>47</sup> Benenson, A. S., *Control of Communicable Diseases in Man*, 14th ed, Washington, American Public Health Association, 1985, at pp. 78-82.

<sup>48</sup> Smallpox: *Crayton v Larrabie* 220 N.Y. 493; 116 N.E. 355 (1917). TB: *Greene v Edwards* 263 S.E. 2d 661, 663 (1980). Cholera: *Hurst v Warner* 102 Mich. 238 (1984).

<sup>49</sup> 220 N.Y. 493; 116 N.E. 355 (1917).

<sup>50</sup> at pp. 501-503, (at p. 358).

<sup>51</sup> *Kirk v Wyman* 83 S.C. 372, at p. 378; 65 S.E. 387 (1939), at p. 389.

However, the indiscriminate use of quarantine was successfully challenged in the United States even in 1900. In *Jew Ho v Williamson* <sup>52</sup> an ordinance quarantining twelve blocks in San Francisco, where 9 people had died from plague, was challenged on the ground that it was discriminatory. Authorities had specifically exempted non-Asian homes from the quarantine. Although the court made it clear it would uphold any reasonable health regulation that protected the public from epidemics of a contagious diseases, the court found the quarantine 'overly broad'. The object of health regulations was to confine the disease to the smallest number of people. The quarantine imposed failed to do this, (effectively restricting 10,000 persons) and was therefore a subterfuge for discrimination and unreasonable. <sup>53</sup>

This case illustrates the US courts' intolerance of overly broad restrictions on personal liberty in the early 1900s. However, Merrit argues that this marked a change from the position prior to this period where courts '... showed little concern for the extent to which [a health measure] might infringe on individual rights'. <sup>54</sup> The economic viability of some measures was a high priority in labelling them as reasonable or unreasonable. For example, in the case of *Hazen v Strong* <sup>55</sup> the Supreme Court of Vermont held that vaccination for smallpox 'had eminent utility in saving expense. If members of a community submitted to inoculation, they could attend to their usual vocations, instead of being confined with a loathsome disease, ...'. <sup>56</sup> The status of the subject was also relevant. Courts appeared to take sides with members of the public whom they considered respectable individuals. For example, in *Kirk v Wyman* <sup>57</sup> a quarantine order was not upheld because the subject was an old respected member of the community. The courts did not apply such a liberal view to prostitutes.

In the post War years in the United States, many challenges to quarantine orders applying to persons suffering from TB were successful. <sup>58</sup>

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<sup>52</sup> 103 F. 10 (C.N.D. Cal. 1900), at p. 22.

<sup>53</sup> *Ibid*, at p. 23.

<sup>54</sup> Merrit, D., 'The Constitutional Balance Between Health and Liberty' (1986) 16/2 *Hastings Centre Report*, 2-8, at p. 4.

<sup>55</sup> 2 Vt. 427 (1830)

<sup>56</sup> cited in Merrit, *supra* note 54, at p. 5

<sup>57</sup> 83 S.C. 372; 65 S.E. 387 (1939).

<sup>58</sup> See for details Parmet, W. E., 'AIDS and Quarantine: The Revival of an Archaic Doctrine', (1985) 14 *Hofstra Law Review*, 53-90, and more particularly *Baleras v Pitchess*, Civil No.

As the principle of reasonableness was derived from the common law the same principle could be applied in Australia by analogy. However, in most public health legislation in Australia there were no due process procedural protections built in leaving the subject without a remedy apart from habeas corpus. The development of the body of administrative law would now provide the subject with the remedy of judicial review of a decision of a government instrumentality such as a public health department. The ground of review may include a denial of natural justice and a consideration of whether the decision was unreasonable and whether irrelevant factors were taken into account.<sup>59</sup> If the decision results in an oppressive interference with rights the lifestyle of an HIV-infected person, he or she may have a remedy. For example, if the terms of a public health order directed a person to abstain from sexual activities involving penetration with or without a condom, this may be regarded as oppressive interference with rights and unnecessary to protect the public interest. Such an order would also be contradictory to provisions in some public health legislation which suggest that persons should use reasonable measures or precautions to prevent the spread of HIV.

In Australia, in addition to the Chinese, other groups were targeted by detention type legislation. Prostitutes thought to be infected with venereal disease were isolated under the ill-fated contagious diseases legislation of Queensland and Tasmania.<sup>60</sup> The legislation permitted the detention of prostitutes until they could be examined for venereal disease.<sup>61</sup> In New South Wales in 1908 section 9 was inserted into the *Prisoners Detention Act* which allowed the detention of prisoners infected with venereal disease for a period of up to nine months until free from infection.

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CA 00617; Superior court LA Co Ca (1980) where the unnecessary confinement of a suspected active TB case led to the award of a large out-of-court settlement.

<sup>59</sup> Hotop, S., *Principles of Australian Administrative Law*, 6th ed, Sydney, Law Book Company, 1985, chs. 7 and 8. This discretionary form of review may be available whether or not a right of appeal against a detention order is provided in a statute (Hotop, at pp. 319-320).

<sup>60</sup> *Act for the Suppression of Contagious Diseases* (1868)(Qld.) and *Contagious Diseases Act* (1879) (Tas.) referred to in Daniels, *supra* note 35, at pp. 64-68.

<sup>61</sup> This was also a feature of legislation in New South Wales where legislation relating to venereal disease was contained in a separate Act *Venereal Disease Act* (1918) which remained in force until 1988 when it was repealed by the *Summary Offences Act* (1988)(N.S.W.). Tasmanian public health legislation currently has a separate section dealing with venereal diseases (ss. 34-53 *Public Health Act* (1962)) as does Western Australia (ss. 297-316 *Health Act* (1911)).

Similarly, during World War I the United States introduced quarantine of prostitutes in order to control the spread of venereal disease.<sup>62</sup> The application of the procedure to prostitutes illustrated how governments were capable of applying procedures in a discriminatory manner against a particular group of persons who were not the only ones suffering from the disease. When challenged in the early 1900s, the courts held that quarantine was a reasonable and proper means of preventing the spread of such a disease.<sup>63</sup> The politics of keeping the army free from disease was an overriding aim of such decisions. Courts decided if health officials had reasonable grounds for believing that a woman was a prostitute they could rely upon their experience to conclude that it was reasonably probable that she was infected.<sup>64</sup> This provided health officials with the power to decide who was or was not a prostitute. Although the courts established a precedent of requiring more than a mere suspicion of infection in order to detain a prostitute<sup>65</sup>, they tended to treat them, as a group, differently from other persons who contracted disease merely by engaging sexual intercourse on a promiscuous basis.<sup>66</sup> However, it was the use of quarantine during this period that '... ultimately forced courts to recognise that quarantine was not always in the best interests of the individual'.<sup>67</sup> At approximately the same period, in both Australia and the United States quarantine or isolation legislation became a complement to police work. Venereal disease legislation or quarantine statutes were used to hold women longer than sentences for prostitution would allow.<sup>68</sup> The remnants of this period of association between the criminal law and public health law is still seen in the delegation of powers to police to detain persons who are the subject of public health orders.

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<sup>62</sup> Full details of American precedent are contained in Parmet, *supra* note 58. Brandt, A.M., states that during World War I 30,000 prostitutes were quarantined to protect men from venereal disease ('AIDS: From Social History to Social Policy' (1986) 14/5-6 *Law, Medicine and Health Care*, 231-242, at p. 233).

<sup>63</sup> *Ex Parte Mason* (1919) 22 Ohio NP NS 21, 30; *Re Fisher* (1925) 74 Cal. App. 225, 239 P. 1100; *State ex re. Kennedy v Heat* 185 S.W. 2d 530 (1945); *Ex parte Martin*, 83 Cal App 2d 164, 188 P.2d 287 (1948); *Ex parte McGee*, 185 P. 14 (Kan. 1919).

<sup>64</sup> *Ex parte Martin*, 83 Cal App 2d 164, 188 P.2d 287 (1948).

<sup>65</sup> *Re Milstead* (1919) 44 Cal. App. 239, 186 P. 170.

<sup>66</sup> which can be seen from the decision in *Ex Parte Dillon* 44 Cal App 239, 186 P. 170 (1944) where the presumption of infection did not apply to non-prostitutes.

<sup>67</sup> Parmet, *supra* note 58, at p. 67, footnotes 85-103.

<sup>68</sup> Parmet, *ibid*, at p. 67; Daniels, *supra* note 35, at p. 68.

The term 'quarantinable disease' under the *Quarantine Act* (1908)(Cth) has not been amended to include AIDS or HIV. The responsibility in this regard has fallen on State Public Health Departments, and legislation in some Australian States specifically permits the isolation, detention and quarantine of HIV-infected persons. For example, section 32 of the *Public and Environmental Health Act* (1987)(S.A.) empowers the Commission in the interests of public health, upon certification that a person is suffering from the specified disease, to request a Magistrate to issue a warrant for the detention of the person at a suitable place of quarantine, for a period not exceeding six months in total. Under section 33 the Commission may direct a person suffering from a notifiable disease to reside at a particular place, refrain from spreading the disease and from performing work, and submit himself or herself to regular examination. Unlike the now amended section 32A provision of the New South Wales legislation, section 33(3) of the South Australian Act enables a detainee to apply to a Magistrate for review of the decision, and section 34(1) provides a right of appeal to a single Judge of the Supreme Court against the Magistrate's decision.

Under the Victorian *Health (General Amendment) Act* (1988) power is given to the Governor in Council to proclaim an emergency for the purpose of stopping, limiting or preventing the spread of an infectious disease.<sup>69</sup> Once an area has been proclaimed, persons of a specified class may be prevented from entering or leaving that area and may be detained within it. In addition, provision is made in section 146<sup>70</sup> for a number of regulations to be passed relating to the examination, testing, counselling, isolation, quarantine, restriction or immunisation of persons, the tracing of persons having contact with infected persons, and the restriction of school attendance because of an infectious disease.

Further, under section 121 of the Victorian *Health (General Amendment) (Amendment) Act* (1989) a person may be detained and isolated if he or she is thought to be infected, is likely to infect others, is a serious risk to public health, has a positive HIV antibody test result and counselling has not successfully achieved 'appropriate and responsible behaviour change'.<sup>71</sup> Like the South Australian legislation the Act provides

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<sup>69</sup> s.123(1).

<sup>70</sup> as inserted by the *Health (Amendment) Act* (1990).

<sup>71</sup> s. 121(1)-(4).

for an appeal to the Supreme Court with respect to an isolation order and lists the matters a court must consider in determining such an appeal. These include: the method by which the disease is transmitted, the seriousness of the risk to others, the past behaviour and likely conduct of the person identified in the order, and the extent of the restriction imposed on the person identified in the order.<sup>72</sup>

In the Northern Territory, section 13 of the *Notifiable Diseases Act* (1981) which applies to HIV-infected persons only allows an infectious person to be removed to hospital when he or she has failed to comply with a direction to adopt such measures necessary for the treatment of or prevention of the spread of that disease. Such a direction must be served personally on the infected person and the Act gives them the right to appeal to a Magistrate who may confirm, vary or revoke the direction.<sup>73</sup>

The legal position in New South Wales when the section 32A case concerning the Sydney prostitute arose was in breach of fundamental liberties. There were no due process clauses in the New South Wales legislation which allowed for a right of appeal. The procedure to be adopted when an infected person was to be detained was not clear. The *Public Health Act* (1991) remedied this situation.<sup>74</sup>

The *Public Health (Proclaimed Diseases) Amendment Act* (1989)(N.S.W.) also redressed some of the grievances that were aired at the time of the detention of the Sydney prostitute. Many of its provisions have been included in the *Public Health Act* (1991). The legislation details the procedure to be adopted when determining what conduct will lead to detention under a 'public health order'. It is a medical officer who makes the decision using his or her discretion.<sup>75</sup> The legislation uses phrases such as 'endangering or likely to endanger life' but gives no guidance on how these might be interpreted. The public health order may contain directions that a person undergo counselling, refrain from specified conduct, undergo treatment, submit to supervision and/or be detained at a specific place.<sup>76</sup>

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<sup>72</sup> s. 122(6).

<sup>73</sup> s. 11-12.

<sup>74</sup> by providing for an appeal to the District Court (s. 41).

<sup>75</sup> s. 23(1)(a)(b) of the *Public Health Act* (1991) refers to an HIV-infected person who is behaving in a way that is endangering, or likely to endanger, the public health.

<sup>76</sup> s. 23(3).



The legislation then specifies that a public health order can be for a period of 28 days.<sup>77</sup> The New South Wales legislation, unlike the Victorian legislation, does not specify that counselling is a pre-condition of an order for detention in that State.

A New South Wales public health order containing a detention direction gives police the power to apprehend and assist in taking the person to the place specified in the order<sup>78</sup> and similar powers if the public health order is later contravened.<sup>79</sup> This would reduce the potential for police to arrest any prostitute or homosexual on any dubious public health ground. Although a warrant is unnecessary, police could only arrest the specific subjects of the public health orders. A person contravening a public health order is guilty of an offence punishable by \$5,000 or 6 months imprisonment or both. Prosecutions can be brought by the police under section 28(1). It seems unnecessary that this should be required. By providing police with prosecutorial and as a corollary, investigatory powers, technically the Act authorises the police to step up surveillance of minority groups such as prostitutes and homosexuals. It may be that police could in time provide the medical officer with information about certain persons of specified classes and then he or she would make a public health order. It is preferable, despite their historical association, that these two arms of preventative detention remain separate.

In Tasmania, under the *HIV/AIDS Preventative Measures Bill* an HIV-infected person may be restricted (s. 21(2)(b)) or be isolated and detained (s. 21(2)(c)) for a maximum of 28 days if he or she, fails to take all reasonable measures and precautions to prevent transmission and fails to inform any sexual contact or person with whom needles are shared, of that fact or, if he or she knowingly or recklessly places another person at risk of becoming infected with HIV and is likely to continue that behaviour (s. 21(1)(a-c)). An order will only be made after an application to a Magistrate who has a duty to consider a number of criteria set out in section 21(3) including whether, and by what method HIV was transmitted, the seriousness of the risk of the person infecting other persons and the past behaviour and likely future behaviour of the infected person. There is however, no chance to review or appeal the isolation order. Neither is there any right of appeal

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<sup>77</sup> s. 23(2)(c).

<sup>78</sup> s. 29(1).

<sup>79</sup> s. 29(2).

contained in the *Public Health Act* (1962) which is supplemental to the HIV/AIDS specific legislation. The concern raised with the New South Wales legislation with respect to police powers to detain members of minority groups would be unlikely to arise with the Tasmanian legislation because police are not granted an investigatory power. They only have the power to act when it becomes necessary to enforce an isolation order that has been granted by a Magistrate. In addition, in order to arrest the subject of the order the police must have in their possession a warrant of arrest that has been obtained by the Secretary of Health from a Magistrate (s. 23(1)).

In Western Australia, Queensland and the Australian Capital Territory existing public health legislation applicable to a wide range of communicable diseases provides for the detention in, or removal of persons to, hospital <sup>80</sup>and allows for regulations to be passed prescribing the conditions and circumstances under which carriers or contacts of infectious diseases may be isolated. Most of the sections specifically grant these powers in the interests of public health. In each of these jurisdictions there is no avenue of appeal against compulsory orders provided for in the legislation.

On closer inspection of the State provisions an interesting trend has developed. In those States with the greatest number of cases - States that are typically more populous, more cosmopolitan, more politically liberal, and with better organised gay communities, such as New South Wales, Victoria and South Australia, the political context of public health policy has militated against the use of traditional public health measures. This has in turn fostered an effort to reconceive the strategy of disease prevention to reflect a greater appreciation of the rights of the individual and of the superiority of persuasive measures over restrictive interventions. It is in these States that the more enlightened AIDS legislation is found. By contrast, in those States with fewer cases such as Western Australia, Queensland and Tasmania (until 1993) where the threat of AIDS is relatively less significant <sup>81</sup> but where the political climate is also more conservative (especially in Tasmania reflected by the fact that homosexual conduct is still illegal despite widespread community

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<sup>80</sup> ss. 251(6) (isolation), 251(8)(forbidden to leave jurisdiction), 263 (removal to hospital) *Health Act* (1911)(W.A.); s. 36 (removal and detention on application to a justice) *Health Act Amendment Act* (1988) (Qld.); r. 4(7) (isolation if refuses to submit to a medical examination), r. 5(8) (detained for such period to ensure 'not a source of infection') *Public Health (Infectious and Notifiable Diseases) Regulations* (1980)(A.C.T.).

<sup>81</sup> as depicted in Table 2.1 National Centre in HIV Epidemiology and Clinical Research, *Australian HIV Surveillance Report*, 1994 10/2:10.

support and international criticism<sup>82</sup>) recourse to a traditional public health response to epidemic disease has been more typical. This response is manifested by the failure to repeal or amend archaic public health legislation in a manner which would limit the potential for rights abuses to occur. For example, in these States if detention occurs, there is no right of appeal. Tasmania is an aberration to this theory following the passage of the *HIV/AIDS Preventative Measures Act* in 1993. It is the present writer's view that this detailed enactment resulted not because the transmission of HIV is a threat in that jurisdiction but because the legislature was trying to placate the homosexual lobby in that State that had placed intense pressure on the government to repeal existing proscriptions against homosexual activity.<sup>83</sup> Instead of decriminalising homosexual conduct in that State the government attempted instead to build procedural protections into public health legislation and clearly define the circumstances in which HIV testing and isolation would occur so that the at risk groups would have a clear indication of what conduct would not be tolerated.

### 3. BALANCING INDIVIDUAL AND COMMUNITY INTERESTS IN THE CONTROL OF HIV/AIDS

In general, the history of epidemics of infectious diseases from the United States shows that the restriction of individual rights has been justified on the grounds of protection of public order, public health or morals or the rights and freedoms of others.<sup>84</sup> Although there is no case law on which to draw a direct correlation in Australia, analysis of public health reports and historians anecdotal evidence<sup>85</sup> would support the view that a similar stance has historically been adopted in Australia prior to the advent of the HIV/AIDS epidemic. The apathy in pursuing an action against public health

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<sup>82</sup> The United Nations Human Rights Committee in 1994 has held that Tasmania is in breach of Australia's Human Rights obligations by its continued criminalisation of homosexual activity (*Toonen v Australia* CCPR/C/50/D/488/1992).

<sup>83</sup> This matter was considered in detail in chapter two, footnote 115.

<sup>84</sup> *Jacobson v Massachusetts* 197 US 11 (1905), which gave the 'green light' to compulsory vaccinations during smallpox and *Jew Ho v Williamson* 103 F. 10 (C.N.D. Cal. 1900), where the court made it clear it would uphold any reasonable health regulation that protected the public from contagious diseases. See generally, Parmet, *supra* note 58, 53-90.

<sup>85</sup> For example, that of Lewis, *supra* note 28; McCleod and Lewis, *supra* note 46; Daniels, *supra* note 35; Cumpston, J.H.L., *The Health of the People*, Canberra, Roebuck Books, 1978, at p. 8.

departments is by and large a product of the lack of constitutional safeguards. It is arguable that the imposition of laws designed to elevate and protect the interests of the community above those of the individual, during the 'AIDS crisis' could well be justified from the standpoint of history alone.

The liberty and privacy of HIV-infected persons is threatened by coercive provisions and there is potential for restrictive measures to be aimed at them, including compulsory testing, isolation and quarantine orders. Minority groups such as homosexuals, IV drug users, prostitutes and prisoners are targets for the imposition of public health laws and policies that may be both restrictive and wrongfully discriminatory.

Legislators have been conscious of this and have enacted general provisions to safeguard individual liberties. For example, section 39 of the *Victorian Health (General Amendment) Act* (1988), provided for an amendment to be made to the *Equal Opportunity Act* (1984)(Vic.) to protect against discrimination on the basis of the presence of a disease-causing organism in the body. Section 4(aa) of the latter Act states that it is unlawful to discriminate on that ground 'unless the discrimination is reasonably necessary to protect public health'. This provision is a modern example of legislation attempting to strike a balance between individual and community interests.

In addition, section 119 of the *Victorian Health (General Amendment) Amendment Act* (1989) lists a number of principles to be considered when applying various provisions of the *Health Act* (1958)(Vic.) to communicable diseases. The principles endorse the right of an 'individual who is suffering from an infectious disease' to be protected from unlawful discrimination, to have his or her privacy respected, to receive information about the medical and social consequences of the disease and to have access to available treatments. However, to these principles a proviso is added: individual rights should not infringe on the well-being of others (s. 119(e)).

It has been seen that compulsory notification, testing, examination and isolation and quarantine are public health measures where there is possible conflict between individual and community interests in the enforcement of the measures. These practices will be examined in the context of AIDS to see if enforcement of such measures to the detriment of individual rights is justified in the interests of community health.

## COMPULSORY NOTIFICATION

Notification involves the obtaining and dissemination of information. This could invoke a claim of a breach of privacy. Privacy involves more than what Alan Westin has called, 'the claim of individuals, groups, or institutions to determine for themselves when, how, and to what extent information about them is communicated to others.'<sup>86</sup> It is easy to see a conflict arising between the individual's claim to privacy and the public health, safety and welfare. One cannot realistically talk in terms of a total right to privacy: "[m]an is not only a solitary animal, he is a creature of the herd as well".<sup>87</sup> It is significant to note that Australian courts have, as early as 1937, refused to hold that there is a general right to privacy in Australia.<sup>88</sup> Even in the United States, where the right is generally seen as more entrenched, it is not absolute in the context of contagious disease transmission. In this area, public policy demands that the individual's rights give way to the overriding concern for the general public's health and safety.<sup>89</sup>

Notification provisions appearing in public health statutes would seem at first glance to encourage a breach of privacy. Such provisions were previously intended to cover diseases that were easily diagnosed, highly infectious and curable, for example, plague, smallpox, yellow fever. For those reasons, public health laws conferred very wide powers on doctors and public health administrators. This was supposedly justified, not only on the grounds of protection of the community, but also because treatment could be offered.

Although there is no cure for AIDS, counselling and education are important to the individual suffering from the virus. This is necessary to promote a responsible attitude towards curbing the spread of the disease. Although counselling would need to be undertaken voluntarily to be effective, notification would allow practitioners to make contact with HIV-infected persons in the community and guide those persons towards counselling. Generally notification is least harmful to an HIV-infected person as it tends to place more duties on doctors. Notification gives public health departments

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<sup>86</sup> Westin, A., *Privacy & Freedom*, New York, Atheneum, 1968, at p. 7.

<sup>87</sup> Madwick, D., and Smythe, T., *The Invasion of Privacy*, London, Pitman, 1974, at p.3.

<sup>88</sup> *Victoria Park Racing and Recreation Grounds Co. Ltd. v Taylor and Ors* (1937) 58 CLR 479 per Evatt J (a dissenting judgment, but not on the point of privacy.)

<sup>89</sup> *Kathleen K v Robert B* 150 Cal. App. 3d 992 at 994 (1984) where the court noted that where public health and safety are threatened an individual's right to privacy is not absolute.

some information on the prevalence of AIDS in the community. These reasons alone may justify invasions of privacy. Interference is not 'arbitrary', but in the interests of community health.

However, notification by way of reporting <sup>90</sup>provides only a rough guide as to the prevalence of AIDS in the community as many people may not know they are HIV-infected or may not present themselves for testing to ascertain their status. In addition, notification technically involves a breach of confidentiality and such a breach could have detrimental consequences for an HIV-infected person. The fact that doctors have always expressed a reluctance to notify public health authorities, especially with respect to STDs, may indicate their concerns about respecting the privacy and confidentiality of their patients. <sup>91</sup>

Disclosure of personal information relating to HIV status raises the conflict between the duty of confidentiality and the duty to protect third parties against foreseeable transmission of HIV. Except in extreme cases where it is clear that a third party is in foreseeable danger of contracting the virus, the release of sensitive information beyond the scope of the individual's consent abrogates the right to control information about oneself. Possible consequences of such disclosure include discrimination in the workplace, stigmatisation and ostracism. <sup>92</sup>

Pre-existing public health statutes in Australian States and Territories failed to impose any statutory safeguards on the usage of information gained in the course of examining or testing persons suffering from infectious diseases. This is in direct contrast to the position in the US where public health statutes do contain confidentiality clauses. This may be due in large part to the fact that US States are constitutionally required to safeguard the confidentiality of information reported to public health departments. <sup>93</sup> However, the advent of the AIDS epidemic has led some

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<sup>90</sup> The distinction that is often drawn between notification for epidemiological purposes and for reporting purposes is not being debated here although arguably the former is less justifiable on the grounds of being a direct benefit to a particular community's health.

<sup>91</sup> Lewis, M., 'From Blue Light Clinic to Nightingale Centre: A brief History of the Sydney STD Centre and its Forerunners: Part 1: V.D. in Europe from Colonization to 1945', *Venereology*, 1988, 1/1:3-9, at p. 6 for details of reluctance of doctors to notify venereal diseases in Australia and in the US. See also Chase, *supra* note 15, at p. 20-22.

<sup>92</sup> Tillet, G., 'The Resolution of AIDS-Related Disputes' (1990) 1 *Australian Dispute Resolution Journal*, 12-17; Godwin, J., 'AIDS Legal Workshop Legal Advocacy and HIV/AIDS Casework' (1990) *National AIDS Bulletin*, July, 12-17.

<sup>93</sup> *Whalen v Roe* 429 US 589 (1977).

Australian State legislatures to attempt to provide protection for HIV-infected persons in the face of notification requirements.

Legislation in some States and Territories has been enacted which provides for procedures to be adopted in cases of disclosure by doctors and health officials of information relevant to both HIV-infected persons and health departments. All States and Territories require that the information about HIV infection status to be referred to the Health Departments in coded formats. Legislation also imposes duties to maintain confidentiality and records. For example, section 42 of the *Public and Environmental Health Act*, (1987)(S.A) requires that information obtained in the course of official duties relating to another person not be intentionally disclosed unless the disclosure is made in the course of such duties, with the consent of the person concerned, or is required by a court or legal tribunal. Similar provisions are contained in section 37 of the *Public Health Act* (1991)(N.S.W.) and section 19 *HIV/AIDS Preventative Measures Act* (1993)(Tas.). In 1989 the New South Wales legislature placed restrictions on reporting proceedings.<sup>94</sup> The Victorian, Queensland and Tasmanian legislation states that the privacy of persons to be tested must be maintained.<sup>95</sup> The availability of suppression orders to prevent the publication of information to identify an HIV-infected person is covered in some public health and evidence legislation. The matter will be covered in more detail in chapter six.

As to confidentiality of medical records, section 130(5) of the Victorian Act requires maintenance of records relating to the incidence of HIV by restricting a medical practitioner from divulging the identity of the person whose blood is tested to either a blood facility or the blood tester. Section 36 of the *Public Health Act* (1991)(N.S.W.) and s. 18 of the *HIV/AIDS Preventative Measures Act* (1993)(Tas.) also contain directions relating to the inspection of medical records. Health Departments in several States and

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<sup>94</sup> The restriction may only be implemented on application by a party if the Judge does not act on his own volition (s. 50oK *Public Health (Proclaimed Diseases Amendment) Act* (1989) which was amended as s. 35(3) of the *Public Health Act* (1991). A similar restriction is contained in the Tasmanian legislation under section 21(8) of *HIV/AIDS Preventative Measures Act* (1993) except it is not dependent on a judge for implementation but is as of right.

<sup>95</sup> s. 128 of the *Victorian Health (General Amendment) Act* (1988), s. 48 *Health Act Amendment Act* (1988) (Qld.) and s. 17(3) *HIV/AIDS Preventative Measures Act* (Tas.) are HIV-specific.

Territories have issued policy directives on the confidentiality of health records.<sup>96</sup>

These provisions do not specifically permit police to have access to this confidential information. In fact, the Western Australian Police defended their establishment of an AIDS List in 1990 on the ground that the Western Australian Health Department refused to supply them with names of HIV-infected persons, thus requiring the police to draft their own list for their protection.<sup>97</sup> The practice of establishing an AIDS List had been revealed during a Parliamentary Committee Inquiry into Police Practices in general.<sup>98</sup>

There have been reports that Victorian police check the HIV status of people being questioned or in custody.<sup>99</sup> The practice was defended by Chief Inspector Denis Cairns as necessary to protect the safety and welfare of police officers. New South Wales police have been issued with a specific circular pertaining to this issue and the confidentiality of HIV-infected suspects and accused persons.<sup>100</sup> An earlier circular<sup>101</sup> allowed police to record notes which identified people suffering from HIV or AIDS. Circular 89/144 notes that 'it is the offender's behaviour that should be recorded, not whether they have HIV or not'.

The keeping of a list of unconfirmed HIV-infected persons is discriminatory. Labelling a person as infected with HIV without a confirmatory AIDS test is prejudicial since it is open to breaches of confidentiality in the absence of any procedural safeguards. The effect that such breaches of confidentiality may have on an accused's life and family is not justified on the ground of protecting the police or the public in general. Selective enforcement could be detrimental to established programmes. The US Joint Sub-

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<sup>96</sup> *Health Commission of NSW Circulars 82/369 and 84/82; Queensland Privacy Guidelines for Hospitals*, Department Standing Committee on Privacy and Health and Medical Records, April 1986; *Western Australia Health Department Guidelines for Release/Access to Health Records* 1986; *South Australian Health Department Guidelines Regarding the Release of Information*. (Information obtained as a result of personal correspondence with respective Health Departments.)

<sup>97</sup> Meertens, G., 'Police keep record of AIDS suspects', *West Australian*, July 3 1990, p. 1.

<sup>98</sup> WA Legislative Assembly, *Report of the Select Committee Appointed to Inquire Into the National HIV/AIDS Strategy White Paper*, Perth, June, 1990.

<sup>99</sup> 'Police Database of HIV Positive People', (1991) 2/3 *National HIV/AIDS Legal Link Newsletter*, 1-2.

<sup>100</sup> Police Circular 89/144. NSW.

<sup>101</sup> Police Circular 89/142. NSW.



Committee on AIDS in the Criminal Justice System, in their report into AIDS and the criminal justice system, were strongly of the view, that

no individual should be identified directly or indirectly as having AIDS unless and until the accuracy of such information is confirmed. Procedures to ensure such accuracy must be put in place.<sup>102</sup>

Improvements need be made in the control of police use of computers including greater supervision, more careful logging in of information and controls on who has access to the information. Police need to be advised of the necessity of treating any statement made by an accused person or the subject of a detention order about his or her infected status as confidential. This must be adhered to until the accuracy of such information is confirmed and afterwards unless there is clear justification for disclosure.

In addition, legislation needs to define in what circumstances other parties such as parole officers, emergency personnel and educational establishments need to know the status of an HIV-infected person or his or her test results. Legislation should also establish some procedure where parties can make a claim that they need to know. It is suggested that Health Departments continue to refuse to give information generally to police about the HIV status of persons.

The issue of privacy in relation to HIV/AIDS has also been considered by Australian courts. For example, in May 1989 the Supreme Court of Western Australia granted an injunction preventing news organisations publishing details of an HIV-infected person who possibly infected a prominent woman who had since died from the disease. It was argued by the defendant news organisation that it was in the public interest that people with AIDS who were active in the community be named. The court was urged by the Department of Health and the AIDS Council of that State to maintain the confidentiality of the relevant parties in the interests of promoting testing of HIV-infected persons.<sup>103</sup> The court ruled that the community interest is best served by maintaining the privacy of HIV-infected

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<sup>102</sup> Joint Sub-Committee on AIDS in the Criminal Justice System of the Committee on Corrections and the Committee on Criminal Justice Operations and Budget, 'AIDS and the Criminal Justice System: A Preliminary Report and Recommendations' (1987) 42/7*The Record of the Bar Association of New York*, 901-923, at p. 916.

<sup>103</sup> *X v Sattler and Ors*. Unreported judgment of the Supreme Court of Western Australia, No. 1783/1989, Kennedy J. The issues of privacy and confidentiality relevant to HIV-infected persons will be covered in chapter six.

persons in the hope that other infected persons will come forward for testing and counselling, thus serving to curb the spread of the virus.

### COMPULSORY EXAMINATION AND HIV TESTING

Compulsory examination and testing under public health laws interfere with an individual's claim to privacy. Broadly speaking, preventing the transmission of HIV is at present the only effective strategy to control the HIV epidemic. HIV testing can be useful in helping to prevent HIV transmission where information obtained by testing contributes to the control of HIV transmission. It is necessary to consider the types of HIV testing and the overall utility of such testing in order to determine whether interferences with privacy can be justified on the basis that protection of community health is achieved.

Testing may be of four types, namely voluntary, routine, mandatory or compulsory.<sup>104</sup>

Voluntary testing is only performed with the informed consent of the individual. This form of testing is presently available in most countries to all persons and is actively encouraged. It can generally only be offered if counselling programmes are in operation and confidentiality of results is ensured. The procedure to be followed when voluntary testing is engaged in has been endorsed by the *National HIV/AIDS Strategy* as necessary<sup>105</sup>, but has been legislatively prescribed in public health legislation in Victoria and Tasmania only.<sup>106</sup>

Routine testing is normally performed unless an individual has a specific, cogent and bona-fide objection. This type of testing can be anonymous in the public health context where it is used to ascertain prevalence. However it is open to criticism because it is often performed without consent or even the knowledge of the person tested. Where testing is anonymous it is unlikely to result in confidentiality problems, but, if its net worth is minimal in terms of combating the spread of the virus, then anonymous or routine testing should not be encouraged.

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<sup>104</sup> Somerville, M. A., and Gilmore, N., *HIV Antibody Testing in Canada*, unpublished paper, McGill Centre for Medicine, Ethics and the Law, Montreal, Canada 1988, at p. 12-13.

<sup>105</sup> Commonwealth of Australia, *National HIV/AIDS Strategy: a policy information paper*, Canberra, Australian Government Publishing Service, 1989 at para. 5.2.5 which suggests that voluntary testing be encouraged and procedures set in place to facilitate such an aim.

<sup>106</sup> s. 127(1)(2) *Health (General Amendment) Act* (1988) (Vic.) and ss. 6-7 *HIV/AIDS Preventative Measures Act*. (1993)(Tas.).

The term routine may also be used to refer to testing of specific groups where it is a standard practice. Individuals have the right to decline such testing unless required to undergo it by law. An example of routine testing required by law is blood alcohol testing following a road accident.<sup>107</sup> Such testing could also be labelled compulsory. In fact section 47(i) of the South Australian *Road Traffic Act* (1961) uses the terminology 'compulsory' in setting up the power to take blood from a person involved in a road accident. Under this legislation informed consent does not need to be obtained whereas under the common law it would be.<sup>108</sup>

Mandatory testing covers the situation where testing is a pre-requisite for a person to obtain a specified status, benefit, service or access to a given service. For example, many health insurance policies require an antibody test to be undertaken as a pre-condition for insurance cover.<sup>109</sup> Mandatory testing is also applied to blood and tissue donations.

Compulsory testing involves testing which is required by law or policy. The individual has no choice to refuse testing and cannot avoid it. Presently compulsory HIV testing is undertaken in the defence forces<sup>110</sup> and in some Australian prisons.<sup>111</sup> However, some countries, for example, Germany and the United States, in addition to testing prisoners, have made provision to compulsory test prostitutes, sex offenders and drug addicts.<sup>112</sup>

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<sup>107</sup> as is the case under s. 56 *Road Safety Act* (1986) (Vic) with or without the consent of the person and s. 8H of the *Traffic Act* (1949-1987) N.T.). In South Australia, s. 47(i) of the *Road Traffic Act* (1961) is much more stringent in its application and covers concerns about procedure and protection of the samples obtained. It particularly states the sample should not be taken if it would be injurious to the medical condition of the patient to do so (s. 47(i)(2)).

<sup>108</sup> The common law doctrine of informed consent is based on patient autonomy and requires that patients understand and approve of therapy or procedure that they are about to undergo. The doctrine is considered in its application to HIV in chapter six, pp. 245-246.

<sup>109</sup> Neave, M., 'Anti-discrimination Laws and Insurance: The Problem of AIDS' (1988) 1 *Insurance Law Journal*, 10-23. This area has been regulated by the development of a *Code of Practice* for Insurers.

<sup>110</sup> The instructions for testing are contained in (General) Amendment I PERS 16-6 'ADF Policy for the Detection, Prevention and Administrative Management of Human Immunodeficiency Virus (HIV) Infection', 1989 and issued pursuant to s. 9A of the *Defence Act* (1903)(Cth). Tests were being conducted from 1985. Since that date 107,243 tests in 27,483 entrants and serving members have been undertaken (Flynn, M. J., 'HIV in the Australian Defence Force 1985 - 1993', *Australian HIV Surveillance Report*, 1993, 9/2: 1-5).

<sup>111</sup> The testing policies in Australian prisons are covered in more detail in chapter seven.

<sup>112</sup> 'Mandatory AIDS tests on basis "of slight suspicion" in Bavaria', *Nature*, 1988 333:585. In the United States, as of 1990 17 US States had added mandatory testing requirements for certain groups such as prostitutes, sexual offenders and drug users in addition to prisoners ((1990) 3 *Intergovernmental AIDS Report*, May-June, 1-3); Burris, S. Dalton, H., Miller, J. L.

Statutes permitting such testing may be overinclusive. There is a move in Australia to test elective surgery patients <sup>113</sup>, and to test in certain circumstances, for example, where an individual is charged with a sexual offence. <sup>114</sup>

Instances of compulsory testing provided for in public health legislation have already been covered in this chapter. Compulsory testing under the guise of a medical examination is conceivably provided for in every State and Territory. One specific instance of compulsory testing is provided for in section 121 of the *Health Act* (1958)(Vic.), which outlines the circumstances when HIV testing may be ordered. A 1991 amendment by the *Health (Infectious Diseases) Act* (1991)(Vic.) contains some inherent contradictions with the earlier provision. Under the 1991 legislation, where a care-giver or custodian (including health care worker, police officer or prison officer) could have been exposed and the person suspected of the 'exposure' refuses to submit to an antibody test, he or she will be subject to a penalty. Surprisingly, the legislation received little debate and considerably widens the powers set down in section 121.

To take blood from a person in a compulsory manner is technically an assault because it qualifies as a non-consensual deliberate and intentional touching of another. <sup>115</sup> With the exception of voluntary testing, the remaining classes are prima-facie unlawful in that a person is deprived of a free consent, or his or her degree of freedom to withhold consent is reduced.

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and the Yale Law Project, (eds) *AIDS Law Today: A New Guide for the Public*, 2nd ed, New Haven, Yale University, 1993, at p. 81.

<sup>113</sup> Compulsory testing for all surgical patients began in NSW public hospitals from 1.1.91 in direct conflict with the Federal Government *National HIV/AIDS Strategy*, *supra* note 105, para. 5.2.12). 'NSW begins compulsory testing in hospitals' (1990) *National AIDS Bulletin*, November, 3. There is no legal basis for such testing. However, in Tasmania from June 1993 under the *HIV/AIDS Preventative Measures Act* (1993) in non-emergency cases a medical practitioner, nurse, or dentist may require a person to undergo an HIV test before carrying out a surgical or dental procedure (s. 12(4)). If a person refuses to undergo the test, the legislation does not authorise the health care worker to refuse to treat the patient but requires that they either carry out the procedure or refer the patient to someone who will (s. 12(6)(a)(b)).

<sup>114</sup> Such a policy has also been recommended in the *National HIV/AIDS Strategy*, *supra* note 105, para. 5.2.14 and is covered in Tasmania under the *HIVAIDS Preventative Measures Act* (s. 10(1)) and s. 464 of the *Crimes (Amendment Act)* (1993)(Vic.). This effect of this legislation will be considered in chapter six, pp. 231-232.

<sup>115</sup> The elements of Assault as an offence under the Codes and at common law was covered in chapter three. Generally the act of taking of blood is consented to. It is the subsequent use or testing to which that blood is subjected that is of concern. It is arguable whether at the point when the blood is actually tested there is no consent mainly if the person has not been informed of the purpose for which the blood is being tested. This matter is covered in detail in chapter six, pp. 245-257.

As compulsory testing or screening has been a public health measure used to control communicable diseases in the past (e.g compulsory chest x-rays during TB) it is necessary to examine the arguments for and against HIV antibody testing and in particular compulsory schemes in the context of HIV. This is particularly important also to the criminal law where there are already instances of compulsory blood testing within the criminal justice system, both in the context of AIDS (in prisons) and in other contexts (blood alcohol testing).

### The Utility of HIV Testing

Testing for HIV has many advantages. First, there is ample testimony that the testing of donors of blood, semen and tissue since 1985 has contributed to the safety of supplies of nations implementing such a policy.<sup>116</sup> The fact there was no test available prior to that date has resulted in a fair proportion of HIV haemophiliac and HIV-acquired transfusion cases. With universal screening and selective donor interviewing, the incidence of transfusion-associated or blood product HIV infection appears to be extremely low.<sup>117</sup>

Second, it is accepted that early intervention and treatment can delay the progression of HIV to AIDS.<sup>118</sup> Hence there is general agreement

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<sup>116</sup> As suggested in the *National HIV/AIDS Strategy*, *supra* note 105, at para. 1.4.1. Australia was the first country to introduce the compulsory screening of all blood donations (Penington, D. G., 'The AIDS Epidemic - Where are we going?' *Med J Aust*, 1987, 147:265-266).

<sup>117</sup> The writer has searched medical journals for reported incidents. It appears that the risk of anti-negative blood being transfused remains an issue even in developed countries. However, a 1992 US study which followed-up 158 cases previously attributed to transfusion-associated infection since screening measures were put in place in 1985, found that only 15 could be substantiated (Conley, L.J., and Holmberg, S. D., 'Transmission of AIDS from Blood Screened Negative to the Human Immunodeficiency Virus', *N Eng J Med* 1992, 326: 1499-1500).

<sup>118</sup> Following clinical trials of Azidothymidine (AZT), in a number of countries in the United States and in Australia, it was found that this drug suppresses viral replication, and reduces the number of 'opportunistic' infections in both AIDS and ARC patients. It was thought that AZT prolongs the lives of AIDS infected persons. A study, conducted in Paris, concluded benefits of AZT are limited to a few months, six for ARC and AIDS patients and then only for some patients (Dournon, E., Rosenbaum, W., Michon, C., et al, 'Effects of Zidovudine in 365 Consecutive Patients with AIDS or ARC', *Lancet*, 1988, 2: 1297-1302). This adverse finding was supported by the Concorde Trials in 1992 described in detail in footnote 166 chapter one. Therefore, the correctness of the initial view that AZT slowed progression is now questionable. However, new prophylactic therapy for PCP have been shown to result in a decrease in the number of cases (Sattler, F. R., 'Pulmonary manifestations of AIDS: special emphasis on pneumocystosis', Wyngaarden, J. B., Smith, L.J., Bennett, J. C., (eds) *Cecil Textbook of Medicine*, 19th ed, Philadelphia, W. B. Saunders, 1992, 1932-1942).

within the medical community that people at risk should be encouraged to undergo a test which will reveal to them their antibody status. This will enable the appropriate counselling procedures to be set in place. After the antibody status has been ascertained, the person may be placed on a drug programme to slow the progression of the disease. The coincidence of counselling when conveying test results has been legislatively endorsed in three Australian jurisdictions.<sup>119</sup> While it is imperative that testing occur with such counselling and it would be against general HIV medical practice guidelines if it did not, in the absence of legislative coercion in some jurisdictions it is possible that testing without counselling may occur.<sup>120</sup>

The third point arises from the foregoing. Following testing, an antibody positive person may be encouraged to refrain from engaging in behaviour that places others at risk of acquiring the virus, thus reducing the spread of the virus through the community. There is some evidence from public health departments in Australia that behavioural changes of this type have been successfully implemented.<sup>121</sup> The difficulty is in maintaining such a change over an indefinite period.

Finally, information from HIV testing, can help direct public health programmes. The population of HIV-infected persons in any given community may dictate different needs in the development of policy. In addition, the information obtained from the test can lead to improved understanding of the infection. This may involve the participation of infected persons in drug trials which may assist, at best, in the development of a cure, and at worst in the furtherance of expertise in the area.

Against the perceived utility of the antibody test in these general terms must be weighed its shortcomings.

First, the current antibody tests do not provide a 100% accurate picture. While testing for HIV antibodies is highly reliable - with a sensitivity of

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<sup>119</sup> s. 127(1)(2) *Health (General Amendment) Act* (1988) (Vic.) (pre- and post-test counselling); s. 10 *Notifiable Diseases Act* (1981)(N.T.) (post-test counselling only). *HIV/AIDS Preventative Measures Act* (1993)(Tas.) provides for both pre and post-test counselling of both positive and negative test results (ss.14(1), 15(2)(3) with the exception of blood donors).

<sup>120</sup> In fact, from reading the State reports in the Commonwealth Government, *National HIV/AIDS Evaluation 1991-1992 State Stories Report*, Canberra, Australian Government Publishing Service, 1993, it is clear that counselling procedures are far from routine at testing sites across Australia (at p. 127).

<sup>121</sup> Personal correspondence received from WA Health Department in 1992 and Tasmanian Department of Health in 1993.

93.4%-99.6% and a specificity of 98.6-99.9% <sup>122</sup> depending on the experience of the laboratory personnel in reading the results <sup>123</sup> - a number of false positives and false negative results have been returned. A false negative can be received if a person has been tested during the 'window period'; before sufficient time has elapsed for antibody production between the onset of HIV infection and the time of testing. <sup>124</sup> This time can be between four weeks to three months <sup>125</sup> but may be longer. This situation results in the need for repeat testing, often conducted three months after the first, and then with the same frequency or more depending on a person's behavioural patterns. In addition, the tests cannot predict whether an individual will go on to develop AIDS.

Testing also generates data potentially available to a wide range of persons. Breaches of confidentiality may be a source of personal stress for the infected person and/or his or her family. Indeed the testing itself and conveyance of the results may lead to psychosocial stress, social isolation and stigmatisation of the persons concerned. There is some evidence that this situation is occurring. <sup>126</sup>

The third major shortcoming of testing is that the rate of behavioural changes occurring amongst high-risk groups following antibody testing or even mere knowledge of the disease appears from present studies

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<sup>122</sup> Weiss, S. H., Goedert, J. J., Sarngardharan M. G., *et al* 'Screening for HTLV-11(AIDS agent) antibodies: specificity, sensitivity and applications', *JAMA*, 1985, 253: 221-225. In the 1990s it is thought that the tests are far more reliable than they used to be (Sloand, E. M., Pitt, E., Chiarello, R. M., Nemo, G. J., 'HIV Testing, State of the art', *JAMA*, 1991, 266:2861-2866). Dax suggests that as a supplemental test to distinguish true from false positive screening results, the Western Blot, with the application of strict interpretation criteria, is highly specific and 'still the stalwart in anti-HIV testing strategies' (Dax, E., 'HIV Western Blot test' [letter] *Med J Aust* 1994, 160: 808).

<sup>123</sup> Saag, M. S., states that in last few years novel techniques have been developed that detect viral protection products or amplify minute fragments of viral RNA and DNA to void the pitfalls of antibody testing and the dangers and expense of live virus culture. Instead the main problem he perceives, is finding a clinician who can interpret results correctly ('AIDS Testing, Now and in the Future' in Sande, M.A., and Volberding, P.A., (eds) *Viral and Immunologic Factors in HIV Infection*, 3rd ed, Philadelphia, W.B. Saunders, 1992, 30-54, at p. 33).

<sup>124</sup> 'Serologic Testing for Antibody to Human Immunodeficiency Virus (HIV) - Update - USA', *Communicable Diseases Intelligence Bulletin*, 1988, 3:2-12. Frank, J.W., Goel, V., *et al*, in 'A Critical Look at HIV-Antibody Tests: 1. How Accurate are They?' *Can Fam Phys*, 1987, 33:2005-2011, have identified the risk of a false-positive result of HIV antibody testing to be probably less than 1 in 10,000.

<sup>125</sup> as set out in chapter one, at pp. 31-32.

<sup>126</sup> Tillet, G., Frost, G., 'Social, Occupational and Legal Issues' in *The AIDS Manual*, 2nd ed, Sydney, Albion Street (AIDS) Centre, 1989, p. 75.

to be minimal.<sup>127</sup> Prevention does not of itself require testing. People can be encouraged to behave safely and avoid engaging in high-risk activities. A coercive effort to promote behavioural change has not been successful in the past in preventing the spread of communicable diseases.<sup>128</sup>

Finally, there are some economic costs as a result of implementing testing programmes. The administrative costs of a compulsory scheme have the potential to be overwhelming.<sup>129</sup>

Persons who endorse compulsory testing schemes generally acknowledge the high cost to the community and then limit its application to specific groups. They argue that this is not discriminatory because only those groups at high-risk for transmission are targeted for testing. However, even if such limitations are acceptable, compulsory testing becomes both expensive and discriminatory, and even unreliable, because there is a need to retest individuals. Many people do not clearly fall within a high-risk category group and are therefore hard to monitor (for example, occasional IV drug users devoid of detection in a given community). Testing all members of these groups implies they are likely to engage in behaviour that is risky for HIV transmission. Since HIV is also heterosexually spread, as a matter of logic the entire population engaging in sexual intercourse should be tested.

Proponents argue that irrespective of all these concerns to individual interests, the community benefits outweigh individual costs. This is often based on the tenuous ground that if testing becomes compulsory then it may foster its general acceptance. This may in turn reduce the reluctance of at-risk persons to be tested, resulting in an overall benefit to the community when such persons eventually come forward.

A further argument in favour of compulsory testing is premised on history. Advocates of testing most often rely on the compulsory mass chest x-ray schemes initiated during the TB era (late 1940s to early 1970s in Australia). It is true that compulsory chest x-rays not only gave some

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<sup>127</sup> Becker, M. H., Joseph J. G., 'AIDS and behavioural change to reduce risk: a review', *Am J Pub Health*, 1988, 78:394-410. Guinan, J. J., Kronenberg, C., Gold J., *et al*, 'Sexual behavioural change in partners of homosexual men infected with HIV', [letter] *Med J Aust.*, 1988, 149:162. Frazer I. J., McCamish, M., Hay, I., North P., 'Influence of HIV antibody testing on sexual behaviour in a "high risk" population in a "low risk" city'. *Med J Aust.*, 1988, 149:363-365.

<sup>128</sup> This argument was discussed in chapter two and earlier in this chapter.

<sup>129</sup> For example, the US Centre for Disease Control study found that testing and counselling cost on average US\$45.00 per person: *New York Times*, June 3rd 1987, B8.



indication of prevalence but also facilitated treatment of the infected person and reduced the spread of TB through the population. As stated earlier, the opposing view has been advanced that improvements in hygiene, and the emergence of sanatoria may have been responsible for the decline in statistics rather than compulsory testing schemes.

Those who argue in favour of compulsory testing may also turn to the criminal law for support. An example is the compulsory random-breath testing policies aimed at curbing fatalities from drink driving. In 1976, members of the Australian Law Reform Commission <sup>130</sup> were not convinced at that time that random testing would have a deterrent effect. There is now evidence from a number of studies conducted that there is a link between the implementation of such testing and the penalty provided for breach, and the decline in the statistics. However, it has not been conclusively determined whether the deterrent effect is merely temporary or permanent. <sup>131</sup> Deterrence theory would suggest that people with prior drink driving offences would be more sensitive to the threat of sanction. But reconviction studies appear to contradict this or do not provide a conclusive finding on the point. <sup>132</sup> Hence a compulsory HIV testing scheme may not modify an individual's behavioural patterns either. History does not provide a strong argument for implementation of compulsory schemes.

Compulsory testing is also open to a number of criticisms.

The practical argument against such a scheme is its potential to be discriminatory in application and the possibility of hidden costs including the provision of counsellors and the maintenance of confidential data banks. Further, if results are used in a discriminatory manner by virtue of a process devised by the government then the government may have to provide for those who suffer such discrimination. Thus to compulsorily test a large population may in the end create another class of welfare recipients.

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<sup>130</sup> Australian Law Reform Commission, *Alcohol, Drugs and Driving*, Canberra, Australian Government Publishing Service, Report No. 4, 1976, para. 258.

<sup>131</sup> Studies providing graphs and statistics on the decline in fatal crashes following RBT introduction in New South Wales, Queensland and Victoria appear in Homel, R., *Policing the Drinking Driver, Random Breath Testing and the Process of Deterrence*, Canberra, Federal Office of Road Safety, February, 1986, pp. 18-21 and figures 1.3, 1.4. The deterrence theory is a topic which has been amply written on and covered well in Homel, R., *Ibid*, chapter 2, 'A Model of the Deterrence Process', 22-44.

<sup>132</sup> In fact, the studies by Homel, R., 'Penalties and the drink driver: A study of one thousand offenders' (1981) 14 *Australian and New Zealand Journal of Criminology*, 225-241 and Tittle, C. R., *Sanctions and social deviance: The question of deterrence*. New York, Praeger, 1980, illustrate how difficult it is to apply a universal test to determine whether a legal process is having a deterrent effect.

The second argument flows on from the first. Compulsory schemes may also drive the disease underground. High-risk groups already have the status of 'discriminated against minority groups' in society. Their behavioural changes alone are critical to stemming the spread of HIV. Public health analysts are in unanimous agreement that compulsory testing is guaranteed to discourage these people coming forward and obtaining what limited treatment is available, and more importantly receiving counselling and being encouraged to adopt safer practices.<sup>133</sup>

The third argument relates to the current unreliability of the HIV antibody tests, a point covered in this chapter. Thus widespread compulsory testing would not likely lead to the detection of all or even all but very few cases of AIDS. There is also some merit in the view that whole populations ought not be tested for a disease for which there is no cure. Past experience with compulsory testing is instructive. The success rate of Western countries in curbing the incidence of sexually transmitted diseases is not favourable. For example compulsory pre-marital testing for syphilis in the United States was found to be of limited value generally in curbing the spread of syphilis in that country.<sup>134</sup> The Wasserman test itself was found to be oversensitive, but many people had suffered the social ramifications of assuming that they were infected.<sup>135</sup> In Australia, studies conducted on congenital syphilis before and after the advent of legislation would suggest that there had been no improvement in statistics since the introduction of legislation which prohibited marriage between infected persons<sup>136</sup> and provided for compulsory notification<sup>137</sup>, and compulsory treatment.<sup>138</sup>

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<sup>133</sup> As exemplified by the arguments of Counsel for the Health Department of WA in *X v Sattler and Ors*. Unreported judgment of the Supreme Court of Western Australia, No. 1783/1989, Kennedy J. See also Buchanan, D., 'AIDS Legal Workshop HIV Testing: principles and policy' (1990) *National AIDS Bulletin*, July, 25-29; and Gostin, L., 'The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties' (1989) 49 *Ohio State Law Journal*, 1017-1058, at pp. 1021-1030.

<sup>134</sup> Brandt, A. M., 'AIDS in historical perspective: four lessons from the history of sexually transmitted disease' *Am J of Pub Health*, 1988, 78:367-371.

<sup>135</sup> Cutler, J. C., and Arnold, R. C., 'Venereal Disease Control by Health Departments in the Past: Lessons for the Present', *Am J Pub Health*, 1988, 78/4:372-376, at p. 372.

<sup>136</sup> Lewis, *supra* note 28, at p. 270; and also *Venereal Disease Act* (1918) (Vic.); *Venereal Disease Act* (1918) (N.S.W.); *Health Act* (1911) (W.A.); *Health Act* (1937) (Qld.).

<sup>137</sup> see the Table in Lewis, *Ibid*, on p. 263.

<sup>138</sup> For example, the Western Australian *Health Act Amendment Act* (1915) required the treatment of all infected persons. Other colonies followed suit with legislation being introduced in Victoria (1916), Tasmania and Queensland (1917), New South Wales, (1918) and South Australia (1920).

The final argument against compulsory testing for HIV relates to the changing perspectives on the rights of individuals. Since the period marked by compulsory chest x-rays for TB and compulsory pre-marital testing for syphilis, two events have shaped public health. First, Australia like many other developed countries has entered an age where civil liberties groups are more instrumental in effecting change to legislation and policies.<sup>139</sup> Second, there has been a movement away from elevating the rights of the community over those of the individual in the area of public health. There is now a trend in the area of public health towards balancing competing individual and community interests and moving away from restrictive public health measures. The theme of the 'least restrictive intervention' has gained currency and developed from the reformation of mental health theory and practice. Recent legislative initiatives analysed in this chapter confirm this.

Overall, the implementation of a testing scheme gives rise to legal and ethical debates which revolve around issues of consent, discrimination, obligations of confidentiality and rights to privacy. This concern is endorsed by the World Health Organisation in a communication statement:

whilst screening for HIV may appear a relatively simple approach to some of the complex problems associated with AIDS and HIV infection, in fact screening for HIV is extraordinarily complex from an epidemiological, economic, legal, logistic, political and ethical perspective.<sup>140</sup>

These concerns arise in the application of the criminal law and public health law as in any other body of law. One might first suggest that only small contained groups of persons clearly at risk for infection should be compulsorily tested and there must be some clearly defined aim to be achieved by such testing. However, this would be to suggest that all individuals within these groups posed a risk individually to the community, a view that would likely be unjustified. In addition, how would the exact parameters of the groups be determined. For example, if drug users were to be tested, a decision would need to be made whether to focus just on current users or anyone with a history of drug use. It has been suggested that the

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<sup>139</sup> This was exemplified during 1989 with the detention of the Sydney prostitute under section 32A of the *Public Health Act* (1902) (N.S.W.) and illustrated by media releases as set out *supra* notes 1-3 of this chapter.

<sup>140</sup> WHO, Communication Statement from the Director-General of the WHO, Ref: CL8 1987, April 7 1987, Geneva.

following question should be asked before embarking on a policy of compulsory testing:

Will the testing result in a sufficiently significant reduction in the incidence of HIV infection to justify the cost, the adverse impact on relations between the groups to be tested and health authorities, and the adverse impact on the individuals to be tested? <sup>141</sup>

However, this particular statement does not assist in developing criteria for determining which particular societal groups should be tested and who will have the responsibility for such a decision. By contrast, the *National HIV/AIDS Strategy* illustrates a more enlightened approach in proposing that compulsory testing applies not to particular groups but to a particular circumstance, that is to say, to a

person suspected on reasonable grounds to be HIV-positive, who persistently behaves in such a way as to place other persons at risk of infection, and there is clear indication that the person is likely to continue to behave in such a way. <sup>142</sup>

This circumstance invokes the due process clause in paragraph 5.2.14 of the Strategy. This paragraph requires that a compulsory testing order be a last resort procedure and such an order must be obtained from a Judge in a closed court. A judge may only issue such an order where he or she has

been satisfied on the balance of probabilities that it is necessary and/or in the interests of public health to make such an order, and where the Court is satisfied that either HIV transmission has previously occurred or that others have been exposed to the possibility of transmission wilfully or recklessly.

However, only Victoria and Tasmania provide for court authorised compulsory testing in the manner recommended by the *National HIV/AIDS Strategy*.

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<sup>141</sup> Buchanan, *supra* note 133, at p. 26.

<sup>142</sup> *supra* note 105, para. 5.2.14.

## ISOLATION AND QUARANTINE ORDERS

As already stated quarantine and isolation policies have been methods used in the past to control the incidence of communicable diseases. The question that arises is whether the application of such measures to HIV-infected persons is justifiable in the interests of protecting the public health.

There are a number of arguments against the application of such measures to HIV-infected persons. Experience with the use of quarantine and isolation measures in venereal disease control in the United States show that they can be ineffective, discriminatory, and invidious.<sup>143</sup> Isolation and quarantine are antiquated notions of control originating in an era of very different infectious diseases. They are serious forms of deprivation of liberty - a form of preventative confinement based on what the person may do rather than what he or she has done.

Everyone infected with HIV is a chronic carrier even if he or she remains asymptomatic. HIV infection is unlike infection with yellow fever, smallpox or cholera, where the incubation period is capable of finite identification, and hence specific time periods have been detailed in the legislation mandating the quarantine of persons infected with such diseases.<sup>144</sup> Quarantine for an HIV carrier would be a life sentence with no possibility of 'parole' until the medical community develops a cure. Coercive measures are difficult to justify when there is no hope that enforced isolation and treatment will result in a cure.

Additionally, the sheer number of people capable of transmitting the virus would make a general quarantine or isolation prohibitively expensive and wholly unmanageable. Justice Kirby recognised this when he stated '... with so many millions affected, there is just no place to go for the infected. There is not enough barbed wire. Not enough guards.'<sup>145</sup>

The fact that HIV is not easily transmitted also means that isolation or quarantine are not appropriate responses to AIDS except perhaps in the rare case where HIV-infected persons continue to engage in high-risk

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<sup>143</sup> Brandt, A. M., *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*, New York, Oxford University Press, 1987, 156-160.

<sup>144</sup> The *Quarantine (General) Regulations* (Cth) as amended in 1988 specify certain time periods for which an individual may be quarantined. For example, plague: 6 days (reg. 63), yellow fever: 6 days (reg. 74) and cholera: 5 days (reg. 63).

<sup>145</sup> Kirby, M., 'The Ten Paradoxes of AIDS - Summing Up the Conference' (1988) *National AIDS Bulletin*, May, 27-30, at p. 28.

activities. Suggestions that HIV-infected persons be subjected to isolation and quarantine orders pose serious threats to individual rights through the invasion of privacy and liberty. Nevertheless, there will be cases where an individual disregards the health of unsuspecting partners or other members of society requiring the intervention of public health authorities.

Although Australian public health statutes specify who may decide to order isolation or quarantine, they do not describe a procedure for gathering information and making fair and correct decisions. There are few procedural safeguards clearly set out prior to the exercise of such powers. Few of the post-AIDS public health provisions provide for a right of appeal by an infected person who is to be detained under a public health order.<sup>146</sup> These omissions represent a serious lacuna in the legislation especially since the source of the information may be anonymous or that the infected person does not have the right to cross-examine the source. There is no guidance on how public health officials will determine the 'risk' level of a particular individual. The civil confinement of persons shown to be dangerous in the area of mental health has been condoned for centuries.<sup>147</sup> However, the analogy with mental health has also shown that for the same period psychiatrists have been unable to predict dangerous behaviour with accuracy resulting in at best mismanagement of cases or at worst, abuse of cases. As it is unlikely that any case will be brought by public health officials when the diagnosis is in doubt, the primary issues will be the danger the patient presents to others and the existence of less restrictive alternatives to confinement that might protect the public equally well. Allowing decision makers to predict who will engage in dangerous conduct without any criteria for guidance is one criticism that can be levelled at the 1991 New South Wales public health legislation.

Legislation that has not been specifically enacted to deal with HIV is defective in these respects and must be remedied to prevent detention occurring on the basis of status, such as being infected or being a prostitute,

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<sup>146</sup> The jurisdictions are New South Wales: *Public Health Act* (1902) as amended, by the *Public Health Act* (1991), s. 41; Victoria: *Health Act* (1958) as amended, s. 122(3); South Australia: *Public and Environmental Health Act* (1987) s. 34; and the Northern Territory: *Notifiable Diseases Act* (1981), s. 12. At first glance it may appear that further redress may be obtained by other legislation (for example, *Administrative Law Act* (1978)(Vic.)). Decisions or orders made under public health legislation are subject to review under administrative law principles in order to determine if public officials have acted unreasonably.

<sup>147</sup> *The Concept of Mental Illness in the Mental Health Act 1986*, Law Reform Commission Report (Vic.), No. 31, April 1990, para. 29.

homosexual or drug user, rather than on the basis of high-risk behaviour. The basis upon which HIV-infected persons could be isolated, quarantined or removed to hospital would need to be considered. It is possible to devise a justifiable model of isolation or quarantine. This is discussed below.

#### Is There a Justifiable Model of Isolation of HIV-Infected Persons?

Quarantine or isolation policies must avoid particular groups being targeted. HIV-infected persons should be quarantined purely on the basis of their infected status, not on the basis that they are homosexuals, IV drug users, haemophiliacs or pregnant women. To do otherwise would provoke disrespect for the law. However, if quarantine were applied universally, certain groups, including children, would be held indefinitely. Isolation on the basis of confirmed infection status or on the basis of social status are possibly the only two practical bases for the implementation of such a measure, although the latter has the potential to be discriminatory and therefore should not be encouraged.

Isolation should be based on behaviour, not infection-status. Detention was based on behaviour in the section 32A Sydney prostitute case. The theory behind the detention was a sound one. It was the implementation of the theory that commanded criticism given that it resulted from a lack of understanding of how to both individually and publicly deal with a disease phenomenon such as HIV/AIDS. Isolation according to behaviour has some commendable points. It would most likely apply only to a few persons; would result in less of a drain on housing resources; be less expensive; and, discriminate where appropriate although there is the danger that those singled out will be members of the most politically vulnerable groups. The effect on the remainder of the community would need to be examined should such a scheme be imposed. If other members of the community are discouraged from seeking testing or treatment, then the cost of preventing a few cases of HIV transmission through isolation orders may be to undermine public health efforts for broad population changes in behaviour.

Assuming that isolation is to apply to those who consistently refuse to modify their behaviour it should be a remedy of last resort as it was in the section 32A case. It must be used where an infected person proves him or herself to be recalcitrant following counselling sessions. Before a public health department imposes isolation on an individual, it must be able to provide access for individuals to appropriate services, including drug abuse

treatment, peer support and professional counselling - all designed to foster behavioural change. It needs to be remembered that often the person who is recalcitrant is typically alienated because of infection, may not identify with any group, may have a personality disorder and aggressive outbursts. The public health action should be to monitor the person's continued behaviour, to contact the STD clinic to carry out partner notification, and to support the person when they are ill.

It has been suggested that coercive measures such as 'cease and desist' <sup>148</sup> orders, temporary isolation or any compulsory public health order that is unreasonable because it is too wide or because it carries the threat of a penalty for non-compliance will not achieve the desired behavioural change. Illingworth believes that many health programmes in the area of AIDS seek to change behaviour by manipulating conduct through infringing on autonomy. <sup>149</sup> The same result could transpire through legislative controls. Illingworth's argument proceeds on the basis that if people do not freely come to the conclusion to change their behaviour they will not change it. This is a theory borrowed from Dworkin who has argued that autonomy is central to the moral sphere. <sup>150</sup> However, one might suggest that violating autonomy in this way is justifiable if there are other more important competing values at stake. It is true that even if public health should override individual autonomy as a value, that the general public health may not be served in the long run by legislation that aims to change by manipulation rather than by allowing conscious thought processes. As the 1990s theme in Australia behind curbing the spread of the disease is to 'sustain behaviour change over the long-term' <sup>151</sup>, if such legislative provisions merely manipulate compliance for the short-term rather than the long-term then arguably the public health is not being served. It is the present writer's view however, that manipulation is not incompatible with autonomy so long as people agree to change their behaviour by being manipulated. Therefore, counselling as part of legislation may be regarded as a legitimate instigator of behavioural change. Public health legislation such as

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<sup>148</sup> A term used in US public health HIV/AIDS strategies.

<sup>149</sup> Illingworth, P., *AIDS and the Good Society*, London, Routledge & Kegan Paul, 1990, 22-60.

<sup>150</sup> Dworkin, R., *The Theory and Practice of Autonomy*, Cambridge, Cambridge University Press, 1988: 'the idea of autonomy ... includes ... some ability both to alter one's actions and, indeed to make them effective because one has reflected upon them and adopted them as one's own' (at p. 17).

<sup>151</sup> Commonwealth of Australia, *National HIV/AIDS Strategy 1993- 1994, 1995-1996*, *supra* note 41, at p. 10.



that in Victoria and Tasmania which require counselling prior to intervention is realistic and enlightened.

Those who must forgo their individual rights for the community good should receive the best possible care and conditions. This raises the additional dilemma of where to care for persons who test positive or are convicted of knowingly transmitting the disease. The problem of placement of HIV-infected persons may be why charges were not laid under the AIDS-specific public health provisions that make knowing or reckless transmission of HIV an offence in the section 32A case. Using criminal or mental health provisions<sup>152</sup> instead to avoid the problem of setting up special facilities merely shifts responsibility for infected persons to prison authorities or mental health facilities possibly turning a public health concern into one for the criminal law. As will be seen from chapter seven, prison health facilities are inadequately equipped to deal with HIV-infected persons.

#### 4. CONCLUSION

HIV-infected persons who fall foul of either criminal law or public health law may be subject to detention and other restrictive orders initiated by public health officials. This chapter considered the public health official's powers in this respect. Such powers are quite wide ranging based as they are on the traditional view that the protection of the individual is secondary to the protection of the society. Existing public health legislation that has its roots

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<sup>152</sup> There is evidence from New South Wales and in Tasmania of persons being detained under powers found in other legislation. In New South Wales, mental health legislation was used to detain a developmentally disabled person in a locked ward on the basis of the belief that the person had HIV (reported in Godwin, J., 'Detention of people with HIV/AIDS' (1989) *National AIDS Bulletin*, September, 30-33, at p. 30). Every State in Australia has legislation that would permit and HIV-infected person who exhibited a mental illness or dysfunction, psychopathic disorder, severe subnormality or subnormality and engages in behaviour which threatens the welfare of community members (s. 4, s. 18 *Mental Health Act* (1963)(Tas.); s. 25 *Mental Health Services Act* (1974-1988) (Qld.); s. 29, 32 *Mental Health Act* (1962-1979)(W.A.)) or there is a substantial risk of bodily harm to others and self (s. 21 *Mental Health Act* (1983)(A.C.T.); under s. 7(1) of the *Mental Health Act* (1980)(N.T.); s. 14(1) *Mental Health Act* (1977)(S.A.); s. 8 *Mental Health Act* (1986)(Vic.)).

In Tasmania, the *Alcohol and Drug Dependency Act* (1968) was used to detain a person with HIV who also chronically abused alcohol. In this instance the fact the person was infected with HIV was not listed as the primary reason for detention. However the legislation would enable the detention of HIV-infected persons who were also alcoholics under the justification of alcohol dependency (personal correspondence with Department of Mental Health, Hobart, Tas. 1990). Gostin reports that civil commitment for drug abuse is used to hold HIV-infected drug addicts and impose a course of treatment on them has been fairly common in a number of US States, ('Selected Issues in AIDS and Drug Abuse: Prevention, Treatment and Criminal Justice', in Gostin, L., and Porter, L., (eds), *International law and AIDS: International Response, Current Issues, and Future Directions*, New York American Bar Association, 1992, 211-248).

in an era of highly contagious infectious diseases may allow coercive measures to be imposed on HIV-infected persons. History reveals that treatment, education and behavioural change have been more instrumental in curbing the spread of communicable and sexually transmitted diseases than restrictive measures such as compulsory mass testing, quarantine and isolation.

There is anecdotal evidence that prior contagious diseases legislation in Australia as in the United States has been used by public health officials as an instrument of government oppression of certain societal groups. The older statutes which are still applicable in Australia establish the broad outlines of disease control programmes leaving the specifics to the discretion of the health officer. Such practices have the potential to be discriminatory and although courts have failed to recognise an absolute right to privacy and liberty, such legislation would be incompatible with an individual's claim to privacy and liberty. The aftermath of the section 32A case was the revelation of just how piecemeal and patchwork Australian policies on privacy and liberty of individuals in the area of public health was in the mid-to-late 1980s.

However, Australian State and Territory governments have generally acknowledged that the AIDS epidemic has brought to the forefront issues of individual versus community interests. Accordingly, governments have attempted to strike a balance between these competing interests by recognising that past public health legislation cannot realistically be applied to AIDS. Legal analysis is being dominated by the metaphor of 'balancing', by the elusive problem of deciding what is 'reasonable' and the problem of defining 'rights'. This realisation has led to the drafting of AIDS-specific public health legislation which for the first time appears to consider that individuals have interests that need to be considered and cannot be ignored unless there is convincing evidence. Some Australian governments have been most progressive in perceiving the need to protect the liberty of detained persons by providing avenues of appeal against isolation orders and detailing those factors to be taken into consideration by courts even before the isolation order is granted. Thus the public official's wide discretion has been tempered by signposts.

Throughout this period of change, public health departments and courts must endeavour to protect the interests of community health and those of the infected or at-risk individual. Law makers must decide whether they want provisions to apply only to those with symptomatic AIDS or all those who test positive for HIV-infection. If the former are unlikely to engage in activities

that may infect others after entering the debilitating final stages of AIDS infection, governments should perhaps be directing their attentions to the latter group who have the potential to infect others while they remain asymptomatic.

Public health statutes should not be cumbersome, with complex and over-lengthy due process provisions resulting in the likelihood that restrictive measures may be applied through the criminal law instead. However, in drafting public health legislation that imposes restrictive measures on HIV-infected persons, law makers should consider if the invasion of basic human rights, the financial cost or the practical burdens of a policy are wholly disproportionate to its benefits. If so, then it should not be adopted. Legislation must make clear what options HIV-infected persons have before they may be detained. The section 32A case involving the Sydney prostitute provides an excellent example of a public health department giving every chance to an HIV-infected person to achieve behavioural change. The Western Australian privacy case illustrates that courts recognise that too strident a line on public health will prevent those at risk coming forward.

As the powers of public health officials have been refined, the scope for abuse has been limited. This means that from a procedural point of view an HIV-infected person has more protections in the area of public health than he or she would have done, in the period prior to the advent of the epidemic. With increasing numbers of legislators aware of individual rights and enacting legislation with this in mind then there is solid ground for concluding that the control of the transmission of HIV should remain the domain of public health departments. It is likely that other States will follow the lead of Tasmania and enact more comprehensive HIV/AIDS legislation that adequately sets out the powers of public health officials in this area.

## **CHAPTER 6**

### **AIDS AND THE CRIMINAL PROCESS**

#### **1. INTRODUCTION**

Many HIV-infected persons have passed or will pass through the criminal justice system. They may be charged for an offence involving the transmission of HIV or charged for an offence unconnected with their HIV infection status. The theme of this chapter is to consider how flexible the current system of pre-trial processes and trial procedure including sentencing is in coping with a disease such as HIV infection. However, only those procedural rules and processes that assume importance for an HIV-infected accused person and his or her victim will be addressed. The chapter has been oriented towards considering first the system from the defendant's perspective and the procedures that effect the defendant primarily and then second, by considering the system from the victim's perspective. In some instances matters will assume relevance for both parties, for example, the maintenance of privacy and concerns about HIV antibody testing. On those occasions the issues that concern both parties will be interrelated.

The paramount concerns of an accused person suffering from HIV infection would include being able to negotiate bail rather than being remanded in custody, to expedite the trial hearing and to receive some mitigation of sentence on the grounds of illness, if appropriate. The victim, by contrast, would be concerned to establish if he or she had become infected and whether compensation could be obtained. This analysis of the effectiveness of the current system in light of HIV/AIDS also includes some proposals for change to existing practice and procedure where changes are required.

#### **2. PRE-TRIAL PROCEDURES AND THE DEFENDANT**

This section covers those procedures that generally occur after formal charging and prior to the trial phase. There may be applications made on behalf of the accused to Judges or Magistrates relating to the conduct of the proceedings. These may include applications for bail where the Crown

applies for special conditions to be attached reflecting the HIV status of the accused. There may also be applications made on behalf of the victim, or the police, for HIV antibody testing of the accused. Such procedures warrant consideration in the context of AIDS.

### APPLICATIONS FOR BAIL

Typically, the first stage at which the defendant's HIV status is likely to present a problem, is at the bail hearing. After the initial stage of gathering evidence has passed and formal charges have been laid then the accused may be bailed by the police - 'police bail' <sup>1</sup> or appear in court to be bailed by a judicial officer - 'court bail'. The law with respect to bail has been codified in Victoria (*Bail Act* (1977)), New South Wales (*Bail Act* (1978)), Queensland (*Bail Act* (1980)), Western Australia (*Bail Act* (1982-88)), South Australia (*Bail Act* (1985)) and the Northern Territory (*Bail Act* (1990)), all as amended. In the remaining jurisdictions, the common law relevant to bail must be applied.

Legislative provisions in those jurisdictions with either specific Bail Acts or legislation pertaining to the grant of court bail create a prima facie right to bail. <sup>2</sup> In some States there exists a presumption in favour of bail for certain offences <sup>3</sup> or there is a discretion to admit the accused to bail. <sup>4</sup> In Victoria and Queensland the presumption in favour of bail to the accused is reversed where the accused has committed a further indictable offence while waiting to be tried for another. <sup>5</sup> In Queensland under section 16(3) of the *Bail Act* where a person is charged with an indictable offence involving the use or threatened use of an 'offensive weapon', the presumption in favour of bail is reversed. The term 'offensive weapon' may require some clarification in the future if an HIV-infected syringe is used. Further, in both Queensland <sup>6</sup>

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<sup>1</sup> This power is granted in most States and Territories, for example, s. 34(1)(c)(d) *Justices Act* (1959)(Tas.); s. 17 *Bail Act* (1978)(N.S.W.); s. 6 *Bail Act* (W.A.); s. 16 *Bail Act* (1990)(N.T.); s.7 *Bail Act* (1980) (Qld.).

<sup>2</sup> Bishop, J., *Criminal Procedure*, Sydney, Butterworths, 1982, at pp. 94-103.

<sup>3</sup> s. 9 *Bail Act* (N.S.W.); s. 8 *Bail Act* (1990) (N.T.) except murder and treason.

<sup>4</sup> s. 13 *Bail Act* (N.S.W.).

<sup>5</sup> s. 4(4) *Bail Act* (1977)(Vic.); s. 16(3) *Bail Act* (1980-89)(Qld.).

<sup>6</sup> s. 45 *Drugs Misuse Act* (1986-7) with qualification where the offence is one triable summarily under section 13 of the *Bail Act* (as amended in 1988).

and New South Wales <sup>7</sup> there is a presumption against bail for certain drug offences. This means an HIV-infected IV drug user charged with drug offences would have to argue against the presumption. A presumption against bail in such circumstances is short-sighted, given the incidence of IV drug use and homosexual rapes in the prison environment. <sup>8</sup>

The decision whether to withhold or to grant bail should not be made lightly in the case of an HIV-infected person. The disadvantages and advantages of remanding the accused in custody need to be weighed in the circumstances. There are a number of criteria that need to be considered in deciding whether or not to award bail to an HIV-infected person.

#### (i) Bail Criteria

In those States and Territories with Bail Acts, the legislation has stated that where there is a discretion to grant bail the court must take into consideration only the criteria specified in the relevant Bail Act. These Acts are a codification of the common law principles with respect to bail, which will continue to apply in those States and Territories without bail legislation. <sup>9</sup> Generally the criteria fall into three broad categories: (i) the probability of whether the accused will appear in court; (ii) the interests of the accused; and (iii) the protection and welfare of the community. <sup>10</sup>

In addition to the general criteria, there are also a number of specific criteria that have been considered in non-AIDS related cases. These will be discussed after the general criteria. There has been no clear direction as to the precise weight to be given to one specific criterion over another. This fact has led critics to state that there is no systematic guide to determinations on bail which has resulted in disparities in bail decisions. <sup>11</sup> Under the present scheme all relevant factors should be considered as a whole.

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<sup>7</sup> *Bail (Amendment) Act* (1988), offences under sections 23-28 of the *Drug Misuse and Trafficking Act* (1985)(N.S.W.).

<sup>8</sup> Details of studies confirming this comment are covered in chapter seven.

<sup>9</sup> *R v Hughes* [1983] 1 Qd R 92.

<sup>10</sup> s. 32(1) *Bail Act* (1978)(N.S.W.); s. 4 *Bail Act* (1977) (Vic.); s. 16(1) *Bail Act* (1980-1989) (Qld.); s. 13 and Part C of Schedule to the Act, *Bail Act* (1982-88)(W.A.); s. 10 *Bail Act* (1985)(S.A.); s. 24 *Bail Act* (1990)(N.T.).

<sup>11</sup> Bishop, *supra* note 2, at p. 119.

There are a number of factors which would be pertinent to a bail application made by or on behalf of an HIV-infected person. These warrant examination. There is no doubt that the three general criteria listed above are important in this context.

The first general criterion involves the need to ensure appearance of the accused in court. It would seem unlikely that a HIV-infected person suffering the debilitating effects of the virus would abscond as he or she may require constant medical treatment in the jurisdiction. It is the asymptomatic person that poses the greatest risk in this regard. The same comment could be made with respect to the third general criterion which focused on the need to protect the community. It is unlikely that a person suffering from AIDS would actively engage in behaviour capable of spreading the virus to others whereas the asymptomatic person might do so through ignorance and would then pose a threat to the health and safety of the community. However, there would have to be some evidence of an express statement on behalf of the accused or implication from other conduct that he or she would engage in activities which pose a high risk of passing virus to others. Even if an accused has been charged for a HIV transmission type offence this does not automatically mean he or she will engage in risky conduct.

The health of an HIV-infected person would also be relevant to the second criterion: the interests of the accused. The fact an accused has serious health problems and may need constant medical attention has been a ground for bail in prior cases.<sup>12</sup> However, as stated in chapter one, a person infected with HIV may remain asymptomatic for many years and therefore it is only those persons suffering from AIDS that could successfully rely on this criterion for a grant of bail. It could be argued by those opposing bail in this context that the prison system could provide all the treatment and counselling required.

A number of the specific criteria would also be relevant in considering a bail application from an HIV-infected person.

The first criterion relates to the delay in hearing a case. A New South Wales court has held in the non-AIDS context that if the delay will be substantial then the grounds for allowing bail must be strong.<sup>13</sup> However

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<sup>12</sup> *R v Manning* [1936] ALR 171; *R v Kennedy* [1941] QWN 49; *R v Street* [1944] QWN 24; *R v Southgate* [1960] NSWLR 477. In *Chamberlain v R* (1983) 72 FLR 1, the fact mother had given birth and needed to breast feed her baby was an 'exceptional circumstance' leading to a grant of bail. In fact the health of the accused is a factor to be considered in some bail legislation, for example, s. 10 *Bail Act* (1985)(S.A.) specifically, or under s. 32(1)(b) *Bail Act* (1978)(N.S.W.) which would allow this when considering the term 'interests of the accused'.

<sup>13</sup> *R v Pett* (1958) 74 WN (N.S.W.) 431 per Walsh J at 434.

other cases reveal that generally there must be additional factors in the favour of the accused apart from the delay to give rise to a grant of bail.<sup>14</sup> The HIV-infected accused's right to a speedy trial will be discussed later in this chapter.

The second specific criterion that may be relevant is the probability of a conviction of A. The seriousness and number of charges may also be relevant to this point.<sup>15</sup> As discussed in chapter three, prosecutions for transmission of HIV are unlikely to be successful in most cases due to the problems of proof surrounding HIV infection. If a person is charged with an offence the prosecution face the prospect that the court will, as it has done in other non AIDS-related cases, grant bail where the evidence appears weak and a conviction improbable.

A third criterion to be considered is the incidence of prior convictions. If, for example, an HIV-infected accused has prior convictions for assault and has been charged with assault for conduct which did not involve the transmission of HIV infection, the court would be placed in a difficult position as to whether or not to grant bail. The fact that an accused has prior convictions for a similar offence is related to the probability of his or her appearance at the trial given that he or she could be facing a more severe sentence as a result of those convictions. But the fact that an accused has already committed two assaults might give rise to the concern that a further assault may be perpetrated. This raises the general criterion of the need to protect the health and safety of the public. If the accused commits a further assault it may be one which transmits the virus to another person. The consideration of prior convictions could be criticised as conflicting with the golden thread of the criminal law, 'a person is innocent until proven guilty'. Further their introduction into the decision whether or not to grant bail also requires arbitrary predictions or speculations as to behaviour to be drawn. Nevertheless, the existence of prior convictions has assumed some importance in non-AIDS related bail applications in Australia.<sup>16</sup>

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<sup>14</sup> *R v Southgate* *supra* note 12.

<sup>15</sup> *WCVB v R* [1989] WAR 279 per Ipp J.

<sup>16</sup> Bishop, *supra* note 2, at p. 114 and fn 35. Indeed Warner, K., 'Some issues relating to organised protest and bail', in Sornarajah, M. (ed.); *The South West Dam Dispute*, University of Tasmania, Tasmania 1984, 132-143, at p. 136, states that the protection of the community from the commission of a further offences by denying bail has had a varied reception in Australia (except where current charges were allegedly committed whilst on bail and then bail is almost unanimously denied). In 1990, the New South Wales *Bail Act* was amended to add that when the criterion of protection of the community is being considered in the context of a bail application, the court must have regard to the seriousness and nature of the offence. If it



The criteria involved in bail applications where the accused has been charged for murder raises different considerations. The general rule that emerges from both bail legislation and the common law itself is that an accused charged with murder will be admitted to bail in 'exceptional circumstances'.<sup>17</sup> In *R v Street*<sup>18</sup> the accused's ill-health was considered an 'exceptional circumstance'. It has been held that the grant of bail is a matter of discretion but that the exceptional circumstances which may be required should not be regarded as a closed list.<sup>19</sup> Therefore, both the HIV-infected status of an accused and the fact that medical treatment is necessary would be relevant to the determination as to bail for murder charges. Presumably if the accused is not suffering the debilitating consequences of HIV infection and is presently asymptomatic then the HIV status may not be considered. The accused bears the onus of showing that in the circumstances he or she should be released on bail.<sup>20</sup>

In *WCVB v R*<sup>21</sup> Justice Ipp held that there should be no difference between the court's approach in cases of murder and cases of 'extremely serious' offences.<sup>22</sup> In that case the accused was charged for 96 offences which included a number of 'extremely serious' offences. The accused's statement to the court conveyed to the judge that A might continue to engage in unlawful activity if granted bail and this appeared to be a weighty factor in the court's refusal to do so. It is possible that a court might find the deliberate infliction of HIV in circumstances amounting to either attempted murder or serious assault to be an 'extremely serious' offence. In that situation, the court might not be persuaded that the HIV-infected accused will not desist from engaging in conduct that may endanger the health and welfare of other persons. This view may result in bail being denied.

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is an offence involving sexual assault or violence this is an imprint factor is the effect on the community and the victim (s. 32(c)).

<sup>17</sup> *Lim v Gregson* [1989] WAR 1. Although this is not followed in South Australia, where *Farquar v Fleet* (1989) 50 SASR 490 held that 'exceptional grounds' are not required for bail for murder.

<sup>18</sup> *R v Street* [1944] QWN 24.

<sup>19</sup> *Lim v Gregson* *supra* note 17.

<sup>20</sup> *Lim v Gregson*, *Ibid*, has confirmed that the accused bears the onus per Malcolm CJ, at p. 14 and Kennedy J, at p. 34 and confirmed by *WCVB v R* *supra* note 15.

<sup>21</sup> *WCVB v R*, *supra* note 15.

<sup>22</sup> at p. 283 and supported by the court in *Lim v Gregson* *supra* note 17; and, by Mansfield SPJ in *R v Lythgoe* [1950] QSR 5.

## (ii) Bail Conditions

If bail is awarded, the police may apply for or the court may add some general or special bail conditions. The general conditions usually involve the deposit of money as security for appearance. The special conditions are designed to ensure the defendants attendance on the date to which he or she has been remanded over until. The conditions may also ensure that while released on bail a person does not commit a further offence, endanger the safety or welfare of members of the public, interfere with witnesses or otherwise obstruct the course of justice.<sup>23</sup>

In the context of a person suffering from and being charged for an HIV transmission type offence, a condition for release might be that the accused report for treatment or undergo an antibody test. In any event, however, it may not be necessary to use this provision to ensure the accused is tested for HIV because, legislation relating to the search of the person may allow such tests to be conducted earlier in the investigatory phase and before a bail application is being considered.

In some States there is scope for further conditions to be applied to an HIV-infected person. For example, in setting down bail conditions in South Australia, the court is directed to give special consideration to any submission made by the Crown on behalf of the victim of the alleged offence.<sup>24</sup> Hence orders for HIV testing or treatment could conceivably be included as bail conditions in that State. However, the purpose for which testing is required would need to be specified. Testing the Accused to Reassure the Victim is covered in the next section.

In both Western Australia and Queensland bail could be awarded subject to a condition that the defendant undergo a medical examination which could focus on both the physical and mental condition of the accused. In Western Australia, there is provision in the bail conditions set out in the *Bail Act* (Schedule D, 2(3)) for the judicial officer to make an order under section 36 (1)(a) of the *Mental Health Act* (1962) to ensure the accused undergoes a medical examination as a condition of bail. It is possible that this general provision will be used to ensure that an HIV-infected person suffering some mental infirmity could be tested for HIV. In Queensland, section 11(3) of the

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<sup>23</sup> Part D, *Bail Act* (1982)(W.A.); s. 11 (b)(i)(ii) *Bail Act* (1980-1986)(Qld.); s. 36 *Bail Act* (1978) (N.S.W.); s. 11 *Bail Act* (1985)(S.A.); s. 27 *Bail Act* (1990)(N.T.); s. 5 *Bail Act* (1977)(Vic.).

<sup>24</sup> s. 11(2)(a) *Bail Act* (1985)(S.A.).

*Bail Act* allows the imposition of a bail condition that requires a medical examination of A. The term 'medical examination' has been stated to bear the same meaning under the Queensland *Bail Act* as in section 259 of the *Criminal Code* of that State.<sup>25</sup> In the latter context, medical examination has been defined to include the taking of blood and hair samples.<sup>26</sup> However, taking blood and then subjecting that specimen to a test for HIV antibodies is another matter raising complex issues concerning consent and informed consent.<sup>27</sup> Similar concerns would arise under the Western Australian *Bail Act*. Given these comments, imposing an HIV antibody test under the guise of a medical examination as a condition of bail may not fall within the specific conditions outlined in the legislation. Courts may hold it to be an abuse of discretion to impose a bail condition of a negative antibody test result where this is not a statutory condition.<sup>28</sup>

There is a further condition in Part D (2(4)) of the *Bail Act* (W.A.) that is more likely to be read liberally in the context of AIDS. This Part allows a judicial officer when dealing with a drug user to impose conditions to ensure care and treatment in a specified institution. Such a condition could be used to ensure that an HIV-infected drug user manifesting an intention to infect other persons with a contaminated syringe could have their liberty circumscribed under the head of treatment at an institution.

In Tasmania, section 35(3) of the *Justices Act* (1959) which sets out bail conditions, has been read as not being limited to the making of orders designed simply to secure attendance in court. In *Levy v Strickland*<sup>29</sup> the applicants argued that the bail conditions that had been imposed were objectionable because they went further than ensuring appearance on the remand date by purporting to restrict the lifestyle of the applicants pending the hearing of the charges against them. Cox J held that restrictions on lifestyle

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<sup>25</sup> Carter, R., *Carter's Criminal Law of Queensland*, 7th ed, Sydney, Butterworths, 1988, at p. 241. This question of whether HIV testing is encompassed in the term 'medical examination' is discussed *infra*, pp. 241-245.

<sup>26</sup> s. 259(4).

<sup>27</sup> The issue of consent and informed consent to HIV antibody testing is discussed in detail *infra*: 'Testing to Obtain Evidence to Substantiate the Charge'.

<sup>28</sup> This has already been held by a court in the United States (*People v McGreevy*, 514 N.Y.S. 2d 622 (1987)).

<sup>29</sup> Unreported judgment, Supreme Court of Victoria, 8/1983.

were not necessarily outside the ambit of section 35(3).<sup>30</sup> In addition, the Judge also supported the right of a magistrate to consider the necessity or desirability of conditions to guard against the probability of further offences being committed.<sup>31</sup> However, His Honour did concede that the need for the condition must be balanced against any disadvantage to the applicant.

Therefore, it is conceivable that bail conditions could be applied in the case of HIV-infected accused persons which might have the effect of restricting their lifestyle for the purpose of protecting the public welfare and safety. Such conditions may not be designed to simply ensure attendance in court. In fact, a reading of the bail legislation in other Australian States suggests that conditions can be laid down that serve purposes other than merely ensuring appearance on the due date.<sup>32</sup> However, a blanket judgement that every accused person suffering from HIV constitutes a public health risk, without questioning if a particular individual is aware of and willing to abide by risk-reduction guidelines, would be misguided.

It is possible that an HIV-infected person could be released on bail under a home-detention order. In 1990, Western Australia was the first Australian State to amend bail legislation to permit home detention as a condition of bail (Schedule D 3(1)). Two decisions have been reported in connection with the grant of home-detention in non-AIDS related cases. In *Everett*<sup>33</sup>, although the accused was charged with serious offences, including kidnapping, Justice Ipp held that he was entitled to home detention because the evidence on which he could be found guilty was at best circumstantial.<sup>34</sup> Such an application was denied by the same Judge in *Quartermaine*<sup>35</sup> where he held that A's long history of offences, thirty in all, indicated a predisposition towards violence, rendering him unsuitable for home detention. Home-detention is a preferable scheme for an HIV-infected person to being held in the prison.

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<sup>30</sup> Warner, K., 'Some issues relating to organised protest and bail', in Sornarajah, *supra* note 16, at pp. 132-144.

<sup>31</sup> For this point he relied on the decision of Sholl J in *R v Light* [1954] VLR 152, at p. 158.

<sup>32</sup> s. 11(2)(b) *Bail Act* (1980)(Qld.); and s. 5(2)(b)(c) *Bail Act* (1977)(Vic.).

<sup>33</sup> unreported judgment Supreme Court of WA, 9010/1991.

<sup>34</sup> It must be noted however, that the accused escaped while on home detention and there have been few recorded instances of this scheme being used in Western Australia since.

<sup>35</sup> unreported judgment Supreme Court of WA, 8981/1991.

Bail conditions could also serve another useful purpose in the AIDS context. As the criminal justice system selects large numbers of persons at high risk of infection and transmission of infection to other persons, it has the unique ability to educate accused persons through the use of bail conditions. As noted in chapter two, property crime is rife among IV drug users. Many IV drug users that could be at risk for HIV-infection will pass through the criminal justice system. Bail conditions have been imposed in the past on drug users which have included attendance at a treatment clinic. In a similar manner, conditions could be imposed on an HIV-infected person to attend for counselling and education. While this would be an extension of the present purpose of bail conditions it is arguably a useful extension from the standpoint of the accused person and the community. Leaving aside the issue of whether coercive attempts at behavioural change will be successful in the long-term, the case for the imposition of such conditions is arguably justified where the individual has acted in a manner which has placed others at risk of acquiring HIV.

### (iii) Bail Applications Concerning HIV-Infected Persons

Few reported cases have come before the courts where an HIV-infected person has applied for bail. In Tasmania, bail was originally opposed by the police in a case of an HIV-infected person on an assault charge by spitting, on the ground that releasing the defendant was not in the public's interest.<sup>36</sup> The prosecution put to the court that where a person was infected with HIV an act of spitting at another was 'the kiss of death'. Bail was denied on the basis that the Magistrate had no confidence that the defendant would not commit further offences while on bail. If this was the sole reason for the decision it would be in accordance with the general bail criteria outlined earlier in this chapter. However, the Magistrate also made the comment that protection of the public interest was one of the primary functions of bail. Given that the offence of assault would, in absence of prior convictions or a previous failure to surrender to custody, normally give rise to a grant of bail, it is arguable that this Magistrate remanded this defendant in custody because the defendant was HIV-infected. Alternatively, the defendant may have been remanded because suitable conditions for bail were not put before the court. Bail was later granted after the defendant had been in custody for four days,

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<sup>36</sup> The case is reported in Browne, R., 'Equal Before the Law?' (1990) 15(2)*Legal Service Bulletin*, 87-88.

following an application to the Supreme Court under section 304(1) of the *Criminal Code*. This provision allows the Supreme Court to admit a person to bail where it has previously been refused. The conditions attached to the grant of bail in this case were that the defendant not approach the complainant or venture within a specified distance of the complainant's business where the original incident occurred.

Relying on the arguments advanced by the police in the Tasmanian example, where a person is infected with HIV and appears to pose a threat to the public then they should be remanded in custody. What is not clear from the Tasmanian decision is whether the police will be likely to argue in a later case that being infected with HIV itself is a threat to the public welfare. It appears that a later court will have to rule on what constitutes a 'threat to the public'. The trend seems to favour an interpretation of 'threat to the public' restrictively in the context of HIV cases.<sup>37</sup>

Presumably the sensible approach in this situation would be to consider whether the accused is charged for a HIV transmission offence or is in court on charges unrelated to his or her infected status. In the latter situation, it is hard to see how the accused could be considered a threat unless he or she has a pre-disposition towards violent behaviour. Where the accused has been charged with a HIV transmission type offence, other circumstances must be considered before the court can simply declare that the accused would pose a threat if released. In such a situation, the court will have to weigh the likelihood of threat to the public with other factors including the accused's state of health.

There have been other reported incidences where bail has been denied to an accused in the context of HIV infection. In 1991, a Victorian Magistrate imposed a 'no sex' order on a male prostitute infected with HIV as a condition of bail. He had been charged for the offence of conduct endangering life under section 22 of the *Crimes Act* (1958) (Vic.) after allegedly running a brothel from his home while knowing he was HIV positive.<sup>38</sup> This provision requires recklessness as to the mental element, and intentional endangering of life is not required by the provision. This case would have been an appropriate one for imposing a bail condition on the defendant that he attend counselling if he was not already doing so.

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<sup>37</sup> It has been reported that in New South Wales a Magistrate denied bail to an accused for 10 days because she was reportedly infected with HIV and hence a threat to the community (Godwin, J., 'AIDS Legal Workshop, Legal Advocacy and HIV/AIDS Casework' (1990) *National AIDS Bulletin*, 12-17, at p. 14).

<sup>38</sup> 'No sex order on AIDS man', *West Australian*, June 15 1991, p. 41.

These examples indicate that judicial officers and other court personnel may not be fully aware of the characteristics of HIV infection. In addition, they are not fully cognisant of the range of bail conditions that they have at their disposal which would serve to both educate the public and the accused and protect the community against the spread of HIV.

### APPLICATIONS FOR HIV ANTIBODY TESTING

During the period of detention the police may need to conduct some investigatory procedures. These may focus on searching the person and obtaining bodily samples from him or her, seizing physical evidence including weapons such as needles, and subjecting physical evidence to scientific or forensic procedures. Apart from the normal requirements of searching for weapons and obtaining fingerprints and samples from clothing and skin, of more concern and controversy is the need to obtain blood samples from the suspect. This is particularly so where the detainee is suspected of committing a sexual offence involving sexual intercourse, or where offences aimed at transmitting, attempting to or threatening to transmit the virus to another person are alleged.

There are other instances arising in the criminal process where knowledge of an accused's antibody status might be required. There may be requests for HIV testing as a condition of bail and during the sentencing process. Testing might be considered for purposes of court security. Finally, a testing application from the victim might be considered in circumstances where the true knowledge of the accused's antibody status may be helpful in determining the nature of the medical care needed for the victim, if any. One question that emerges is whether there is currently any legal basis for the compulsory testing of an accused person in any of these situations. The arguments for and against compulsory HIV antibody testing in the public health arena have been covered in chapter five. Testing for the purposes of court security, at the request of the victim (which could occur as a pre-condition of bail) and by the police for evidential purposes, are considered below.

#### (i) Testing for purposes of court security

In Australia there have not yet been any requests for testing of accused persons to determine if any special courtroom procedures are required when dealing with an HIV-infected accused. The procedures that

have been adopted in the United States for these purposes have included the wearing of surgical gowns and gloves by court personnel and restricting the movement of the accused in the courtroom by wearing leg irons or prohibiting the accused from actually being present in court. Upon legal challenge, such procedures have been held to be a violation of due process.<sup>39</sup> There has been one reported instance of an Australian Magistrate imposing a physical restriction on an HIV-infected person's appearance.<sup>40</sup> Testing the accused on the ground of the need to maintain court security would not be justified in the absence of any scientific basis to substantiate that HIV can be transmitted through casual social contact.

Rather than subject an HIV-infected accused to an HIV test, if a defendant exhibits unruly behaviour the Judge with a concomitant duty to protect court personnel, counsel, jurors and spectators might have to consider cautioning the accused and then removing him or her from the court-room. In the alternative, judges might consider advising the accused at the outset that so long as his or her behaviour is non-violent then no outward precautions to prevent the spread of disease will be taken. The problem is no different from that encountered in a courtroom where a person with a long history of violence is being tried.

#### (ii) Testing the Accused to Reassure the Victim

Paragraph 5.2.14 of the *National HIV/AIDS Strategy*<sup>41</sup> suggests that compulsory testing be considered in the case of persons charged for a sexual offence or on the request of the victim (or his or her guardian) of the

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<sup>39</sup> *Wiggins v Maryland* 315 Md. 232, 554 A.2d 356 (1989) where the court reversed a murder conviction and held that the wearing of gloves unfairly prejudiced the jury against the defendant. Although the court did not state this point, it is also significant that visible precautions may amount to a breach of confidentiality because they reveal the accused's HIV status. In addition, they are likely to predispose observers to the view that the accused will act in a manner at risk for transmitting the virus when that might not be substantiated. The issue of confidentiality in the courtroom is discussed infra under the heading 'Privacy in the Courtroom'.

<sup>40</sup> There was a newspaper report that, in New South Wales, police escorted a person suspected of being HIV-infected into a courtroom in protective clothing and the Magistrate warned the prisoner that he may have difficulty obtaining legal representation because of his suspected HIV infection. The Magistrate was subsequently reprimanded ( *Sydney Morning Herald*, May 8 1987, p. 1).

<sup>41</sup> Commonwealth of Australia, *National HIV/AIDS Strategy: a policy information paper*, Canberra, Australian Government Publishing Service, 1989.



alleged offence.<sup>42</sup> There is only one State in Australia where legislation has been passed which specifically provides for the HIV antibody testing of one person for the benefit of another. Under the Tasmanian *HIV/AIDS Preventative Measures Act* (1993) testing can be conducted where it is 'necessary to determine the medical treatment of another person who may be at risk of becoming infected with HIV and whose condition, or suspected condition, in the opinion of a medical practitioner, is directly or indirectly caused by the person required to undergo the HIV test' (s. 10(2)). It is the Secretary of Health who has the authority to apply for the test and not the police. It is not stated in the Act that the police can request such testing or that they can apply to the Secretary. Nor is it clear whether the victim can initiate the application. The terms of section 10(2) would clearly cover a police officer who suffered some injury at the hands of an accused which might have involved transmission of HIV. The Tasmanian legislation permits such testing directly or where the accused person refuses to consent on application to a Magistrate by the Secretary of Health (s. 11). This legislation is considerably wider than that envisaged by the Strategy. For example, whereas the Strategy limits such testing to victims of sexual offences, section 10(2) of the *HIV/AIDS Preventative Measures Act* (1993) implies that the victim need not be a victim of a sexual assault, but, that the provision will apply to a person who in a situation where HIV might be transmitted.

Victoria has public health legislation allowing testing of one person for the benefit of another in certain circumstances although it is not HIV-specific. Section 120A of the *Health Act* (1958) as inserted by the *Health (Infectious Diseases) Act* (1991)(Vic.) provides for a Magistrate to order a person who may have transmitted a specified infectious disease, including HIV (and any form of Hepatitis), to a care-giver or legal custodian, to be tested. Section 118(c) defines a care-giver or legal custodian in a manner which would include police and prison officers. Therefore, an application for testing could be made in circumstances where a person resisted arrest by biting a police officer.

The *Health (Infectious Diseases) Act* extends the compulsory testing provisions set out in section 121 of the *Health Act* (1958)(Vic.), which

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<sup>42</sup> *Ibid*, The Strategy also suggests that testing only be conducted as a last resort following an order of a court proceeding *en camera* and with appropriate procedural safeguards. In issuing the order the Judge must be 'satisfied on the balance of probabilities that it is necessary and/or in the interests of public health to make such an order, and where the court is satisfied that either HIV transmission has previously occurred or that others have been exposed to the possibility of transmission wilfully or recklessly' (para. 5.2.14).

were covered in chapter five. Under section 121, there has to be a reasonable belief that the person being tested had the disease and that he or she posed a 'serious threat to public health'. This phrase is not defined in the legislation. One instance of biting a police officer is not conclusive evidence that the person concerned is a serious threat to the public health. However, section 120A(1)(a) of the *Health (Infectious Diseases) Act* would allow testing to be conducted as long as a Magistrate reasonably believes an incident has occurred where the disease could have been transmitted. The Tasmanian provision is wider than the Victorian provision in that the former allows an accused person to be tested where the victim of a crime is not only a legal custodian or caregiver but, for example, a victim of rape or sexual assault. It is significant that the Tasmanian legislature has placed a provision which allows HIV testing of a person charged with a sexual assault in legislation that is primarily orientated towards health rather than crime. It is perhaps an indication that the Tasmanian legislature believes that HIV transmission is a public health matter rather than one for the criminal law sphere.<sup>43</sup>

As this analysis reveals, in Australia, there has been a slow move towards enacting legislation that would authorise the testing of persons charged or convicted of committing sexual assaults. Tasmania is the only State which specifically provides for HIV testing of an accused person charged with a sexual offence either by consent or by way of court order.<sup>44</sup> By contrast, by 1990 in the United States, eleven States had passed legislation which authorises officials to screen persons charged for or convicted of sexual offences and assaults.<sup>45</sup> The impetus behind the enactment of such provisions in the US is reported to have been to allow victims to be assured that they have not been infected with HIV. But a number

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<sup>43</sup> There is in Victoria provision under the *Crimes Act* (1958) as amended in 1993 to allow blood samples to be taken of persons charged for (s. 464R) and convicted of (s. 464 ZF) sexual offences (to be discussed *infra*). However it is not HIV specific.

<sup>44</sup> s. 10(1) and s. 11(3) respectively of the *HIV/AIDS Preventative Measures Act* (1993)(Tas.). See also *supra* note 43.

<sup>45</sup> Gostin, L., 'Public Health Strategies for Confronting AIDS: Legislative and Regulatory Policy in the United States', *JAMA* 1989, 1261:621-1630, at pp. 1625-1626 and 1630, in 90-93 and Blumberg, M., *AIDS: The Impact on the Criminal Justice System*, Merrill, Columbus, 1990, at pp. 71-72, report that eleven US States have such statutes. The Joint Subcommittee on AIDS in the Criminal Justice System of the Committee on Corrections and the Committee on Criminal Justice Operations and Budget, 'AIDS and the Criminal justice System: A Preliminary Report and Recommendations' (1987) 42(7) *The Record of the Bar Association of New York*, 901-923, concluded that defendants and sentenced persons should not be required to submit to antibody tests to detect the presence of the virus at the request of any personnel at any stage of the process. Further, they concluded that testing should be prohibited unless the offender consents and court-ordered testing is 'unwise' (at p. 917).

of questions arise relating to the justification of such legislation. The first is whether victims of sexual and non-sexual assaults face a serious risk of HIV infection. The second is whether testing provides such persons with useful information in order to justify the testing. As these issues are relevant to Australia also, they need to be considered in turn.

Information from the United States prior to the advent of HIV/AIDS provides evidence that most women who are the subject of rape or sexual assault, are vaginally assaulted.<sup>46</sup> In chapter one it was stated that the risk of transmission from this mode of activity following one contact with the infective agent was minimal. These factors together would suggest that there is a small likelihood of female rape or sexual assault victims becoming infected. Admittedly, traumatic vaginal sex is a risk factor for acquiring HIV infection<sup>47</sup> and the risk of transmission increases for women anally raped or repeatedly raped. The US statutes only appear to focus on female rape and vaginal intercourse. Hence they ignore the fact that males can experience rape also. The risk of transmission increases where anal intercourse is a feature of male-to-male rape.<sup>48</sup>

Admittedly, this quantification of risk is sketchy since there are no recorded statistics either in the United States or in Australia on the risk of transmission of HIV or any other sexual transmitted disease through rape or sexual assault. However, US statutes that allow for compulsory testing of alleged rapists are overinclusive, given the lack of conclusive statistics which suggest that female rape victims are at high-risk for acquiring the virus through that violent episode. Such statutes are also underinclusive, where they ignore male anal rape, an activity which is more likely to result in HIV transmission.

The risk of infection from non-sexual assaults should also be considered. These assaults commonly occur in the context where police or prison officers are engaged in arresting or restraining suspects or prisoners. The incidents of concern involve being bitten or spat on, or being wounded in the course of a fight.<sup>49</sup> In chapter one it was stated that in all these types of

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<sup>46</sup> Holmstrom, L. L., and Burgess, A. W., 'Sexual Behavior of Assailants During Reported Rapes' (1980) 9 *Archives of Sexual Behavior*, 427-439; Estrich, S., *Real Rape*, Cambridge, Harvard University Press, 1987.

<sup>47</sup> Bouvet, E., De Vincenzi, I., Ancell, R., *et al* 'Defloration as risk factor for heterosexual HIV transmission' *Lancet*, 1989, 1:615.

<sup>48</sup> see chapter one, pp. 25-26.

<sup>49</sup> Examples of incidents are contained in chapter three, footnote 114.

incidents transmission of HIV is particularly remote. Bites appear as the most dangerous because there may be a blood to blood connection upon breach of skin surfaces. It is true that intramuscular needlestick injuries are high risk for transmission. The degree of risk is dependent on how much contaminated blood is injected into the victim through the needle. Given the fact that the risk of transmission of HIV during sexual and needlestick incidents, at least, can be equated, it is questionable why only the former and not the latter are singled out for HIV testing. The Tasmanian legislation (s. 10(1)) can be criticised for focusing only on sexual crimes. This fact together with the concerns that have been raised in relation to the US statutes give rise to the question whether the degree of risk should be the sole or major basis for HIV testing of offenders or whether other factors are to assume more importance.

The perceived benefit in HIV testing for the victim therefore needs to be examined. There is no doubt that violent sexual assaults will produce anxiety for the victim, given the incidence of HIV infection in the community generally. The issue is whether legislation requiring compulsory testing serves the victim's interests and whether this factor alone should be of great significance. The fact that the HIV antibody tests are not 100% reliable may increase the victim's anxiety about the antibody status of the defendant if the victim is informed of a false positive or false negative test result, where the assailant has been tested before the 'window period' has passed. In addition, the fact that the offender tests positive does not mean the victim will have acquired HIV. Hence the test itself may elevate the trauma of the actual assault or rape because the victim would have to be re-tested over a period of several months, a period which would be marked by uncertainty.

Court orders in the United States have been reversed on appeal on the ground that the usefulness of testing in the circumstances of the particular case was questionable.<sup>50</sup> However, with the advent of AZT slowing progression of the virus, early treatment could be an incentive for the court to order testing<sup>51</sup> although the usefulness of AZT in this respect was questioned in 1993.<sup>52</sup>

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<sup>50</sup> *Barlow v Superior Court*, 190 C.A. 3d 1652 (1987). However in *Johnetta J. v Municipal Ct of San Francisco*, 267 Cal. Rptr. 666 (Cal Ct. App. 1990) the court found the very fact of the uncertain state of medical knowledge of HIV transmission through saliva to be a strong ground justifying the accused person undergoing an HIV test (at 671).

<sup>51</sup> Blumberg, M., and Langston, D., 'Mandatory HIV testing in criminal justice settings' (1991) 37(1)*Crime and Delinquency*, 5-18, at p. 8.

<sup>52</sup> see chapter one, footnote 166.

In the alternative, victims could ascertain their own antibody status and commence treatment. In any event, if the accused is found to be antibody positive the victim will need to be tested. Requiring the accused to undergo such a test is merely delaying the inevitable as far as the victim is concerned. Evidence reveals that police officers who feel they may have been infected by an accused's behaviour have accepted it as their responsibility to undergo HIV testing to reassure themselves that they have not been infected.<sup>53</sup>

The court must weigh the accused's privacy interests against the government's interest in assisting the victim towards appropriate medical treatment. For the following reasons, it is not clear that there are benefits to the victim that would outweigh the harm to an accused undergoing a compulsory HIV test. First, such testing does not provide survivors with timely and reliable information about the risks of contracting HIV. It may also signal to the populace that these activities are high risk for infection when in reality both statistical and medical evidence does not support such a hypothesis. Second, testing of the accused fails to address the real needs of rape victims. It directs responsibility away from providing more victim-based services such as follow-up counselling and treatment programmes administered by community health where referrals from the criminal justice agencies are received. Third, it perpetuates the dangerous misconception that information about rapists' HIV status is critical to survivors' health. There is no evidence to suggest that testing of the offender as opposed to testing *per se* facilitates a survivor's psychological recovery. Fourth, it sets a dangerous precedent for extending mandatory testing to other groups such as prostitutes. In addition, it gives rise to the query whether the accused should be tested for other sexually transmitted diseases that are more contagious such as syphilis, herpes and hepatitis B. Fifth, currently perpetrators of sexual assaults are singled out for such testing whereas those who commit non-sexual assaults accompanied by similar risk levels escape testing procedures. Finally, if these sorts of provisions are included in criminal statutes, like laws against transmission in the criminal sphere they allow the whole matter of HIV transmission to become a criminal law matter rather than a public health concern. The

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<sup>53</sup> In addition, Police Departments have pamphlets which encourage this course of conduct. For example, in Western Australia, the Police Department has a booklet on 'AIDS Information: Facts for Police Officers'. Also 'Needle and Syringe Disposal/Needlestick Injury Information' to be read in conjunction with the notice appearing in Police Gazette No. 44/87 and Routine Order 4.9.10. The Australian prison warden who was stabbed with an HIV contaminated syringe by a prisoner in Long Bay Jail in 1990 underwent an HIV test immediately and was prescribed AZT on the same day. He seroconverted and has now progressed to AIDS (see for details chapter seven).

Tasmanian legislation by contrast has attempted to focus this issue as a health matter by incorporating testing into public health legislation and providing that orders for testing can only be initiated by the Secretary of health.

In the present writer's view, before any further legislation is passed allowing for the compulsory testing of charged and convicted sexual offenders or perpetrators of non-sexual assaults, a study should be undertaken to ascertain the frequency with which both sexual assault and other assault victims ask for an HIV test. A decision will also need to be made as to whether voluntary submission to such testing should be regarded as a mitigating factor in sentencing. Further, the law should also provide that no further criminal charges or enhanced sentences will result from the information gleaned from the test.

Legislators also need to consider whether a distinction should be drawn for the purposes of testing between a person who is charged and a person who has been convicted of a sexual offence. In the United States, legislation varies in its application to either suspects or convicted persons or both.<sup>54</sup> The Tasmanian legislation focuses only on the person charged with the offence. Legislation that allows a suspect to be tested contradicts the presumption of innocence. An accused should not be forced to provide evidence against himself or herself which would offend the rule against self-incrimination.<sup>55</sup> However, from the point of view of the victim post-conviction testing increases anxiety about the antibody status of the defendant.

The issue of HIV testing of offenders also brings to the forefront the adequacy of current victim services within the criminal justice system. Procedures whereby counselling is offered after rape should include counselling regarding the need to obtain an HIV test. The victim should not delay these procedures merely because he or she is waiting to establish whether the accused is infected. Compensation should be paid to the victim for his or her testing expenses. The victim and the offender should receive follow-up counselling which could be achieved by referral to community-based

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<sup>54</sup> For example, legislation authorising testing of sexual offenders in Colorado and Texas applies to pre-conviction whereas legislation in Illinois, West Virginia, Washington and Indiana only applies post-conviction (McGuire, K., 'AIDS and the Sexual Offender: The Epidemic Now Poses New Threat to the Victim and the Criminal Justice System' (1991) 96 *Dickinson Law Review*, 95-123 at pp. 117-119).

<sup>55</sup> Originally developed to prevent accused answering questions that might subject him or her to a penalty and extended the furnishing of evidence against his or her interests (Byrne, D. M., Heydon, J. D. (eds), *Cross on Evidence*, 3rd Australian edition, Sydney, Butterworths, 1986, at p. 624).

services. The US legislation generally fails to incorporate pre- and post-test counselling which is an important health objective in HIV prevention. The Tasmanian *HIV/AIDS Preventative Measures Act* does provide for counselling, but, it is contained in a provision unrelated to compulsory HIV testing.<sup>56</sup>

When turning to consider the position from the standpoint of the accused one can see why the victim should be tested immediately in order to ascertain whether the victim was already infected prior to the criminal act taking place. This would be of significance where the accused is charged with a transmission offence, for example, with reckless endangerment under section 22 of *Crimes Act* (Vic.). Current Tasmanian legislation does not make it clear that an accused should be told of his or her right to refuse to undergo such testing. This is a significant fact given that the Secretary of Health only has to substantiate the procedure adopted when the accused refuses to consent. One can imagine situations arising where an accused is advised that it is merely an informality for him or her to undergo a test. The procedural safeguards contained in the *Police and Criminal Evidence Act* (1984)(UK) to ensure that a subject has been informed of his or her rights during intimate searches,<sup>57</sup> in the criminal law sphere has no counterpart in Australian criminal law or public health law, with the exception of Victoria.<sup>58</sup> For example, the accused should be advised what use may be made of the results of blood sampling.<sup>59</sup>

### (iii) Testing to Obtain Evidence to Substantiate the Charge

The *National HIV/AIDS Strategy* does not provide for testing for HIV the purpose of obtaining evidence to substantiate a charge against A.<sup>60</sup>

<sup>56</sup> sections 14, 15 appear applicable to section 10(1).

<sup>57</sup> contained in s. 62 and Code C of the *Codes of Practice* annexed to the Act.

<sup>58</sup> The 1993 amendments to the Victorian *Crimes Act* by the *Crimes (Amendment) Act* (1993)(Vic.) sets out that informed consent is required. Informed Consent is defined in terms that would require for the accused to be advised of the purpose of such testing (s. 464S). By contrast, the Tasmanian provision does not set down such a requirement.

<sup>59</sup> *Ibid*, s. 62(7)(8) of *Police and Criminal Evidence Act* and see s. 464S *Crimes Act* (1958)(Vic.) which sets down this requirement.

<sup>60</sup> *supra* note 41. The text of 5.2.14 reads as follows: 'There are other situations where the welfare of others in the community depends on the testing of an individual, and where compulsory testing for HIV may have a place. The only such situations are: ... testing of a person charged with a sexual offence, where an HIV test is requested by the victim of the alleged offence or, if the victim is not competent, by his or her guardian; ...'

The terms of paragraph 5.2.14 of the Strategy may allow the police to apply to a court for a compulsory testing order to allow them to obtain information to substantiate a sexual offence. But, the substance of this paragraph appears to be to limit the testing to situations where it is being done for the victim or for the welfare of others. It is doubtful whether the gathering of evidence is directly for the welfare of others. Similarly, the whole tenor of the *HIV/AIDS Preventative Measures Act* (1993)(Tas.) is directed at the victim's welfare or society in general and not to assist the police in proving elements of the crime. Further, section 11 of the Act which allows an application to be made to a Magistrate for a compulsory testing order, does not direct the Magistrate to consider whether testing may afford evidence to substantiate the charge.<sup>61</sup>

The police may argue that having this power to authorise testing is very important to their ability to detect and prosecute crime. This was exemplified in the outcome of the US case of *Barlow v Superior Court*.<sup>62</sup> In this case, the Defendant had bitten two police officers during a parade. He was charged with attempted murder but the charge was thwarted by the lack of evidence which arose because of the court's refusal to permit testing of the defendant's blood. There is evidence to suggest that HIV testing has been conducted in Australia in some circumstances under police authority.<sup>63</sup> This is occurring either because accused persons are told they have to undergo such a test, or because the police are obtaining their consent to general testing. Such testing has also been conducted to ascertain whether police might have been infected as a result of some confrontation involving an accused suspected of being infected with the virus.<sup>64</sup>

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<sup>61</sup> In fact the provision states:

'When determining whether to make an order under this section, a magistrate shall consider the following matters:-

- (a) whether other person are or have been exposed to the possibility of transmission of HIV;
- (b) the right to information of a person at risk of infection;
- (c) the availability of a proven treatment in relation to HIV.'

<sup>62</sup> 236 Cal. Rptr. 134 (1987).

<sup>63</sup> An individual has been allegedly tested in Victoria following a traffic offence (Note, 'Police Database of HIV Positive People' (1991) 2(3) *National HIV/AIDS Legal Link Newsletter*, 1-2, at p. 2). In Tasmania, in *Palmer* Complaint No. 10282/87 Supreme Court of Tasmania, August 1987 (the full facts were discussed in chapter three: text and fn 117) the forensic reports attached to the court transcripts is testimony of the fact that testing was conducted. It is unclear whether Palmer consented or not.

<sup>64</sup> Note 'Police Database of HIV Positive People', *Ibid*, at p. 2. See *supra* note 53.



There are common law and statutory limits on the powers of police to secure samples from suspects. These limitations and the legality of police procedures for applying HIV tests to a blood sample obtained from an accused person will be considered. This issue is an important one because the securing of evidence in breach of the law will not automatically render that evidence inadmissible as the courts have a duty to consider whether the balance of public interest requires them to exercise a discretion to exclude evidence so obtained.

In order to fully explore this area the powers of the police in the legal process need to be clarified. Police have both an investigative function (including the detection of crime and collection of evidence) and also a prosecutorial function (pursuing, arresting and bringing persons to court). Police are invested with distinct powers for each of these purposes and the functions applicable to one are not to be used in the furtherance of the other function.<sup>65</sup> The collection of blood for forensic purposes falls within the investigative function.

### *Taking Samples with Consent*

The common law does not allow pre-arrest searches to be conducted without the co-operation and consent<sup>66</sup> of the person being searched.<sup>67</sup> In this respect a suspect has the same rights *prima facie* as a person not involved in the criminal process. This rule derives from the fact that a touching without consent constitutes a battery. The basic right to protect one's bodily integrity from unauthorised intrusions forms the basis for the justification for battery liability.<sup>68</sup> However, if an accused person agrees to provide blood then the case of *Carr v R*<sup>69</sup> would support the view that there is nothing unlawful in the request.

Once a person is 'under arrest' or 'in custody' the collection of evidence from that person even with consent may become subject to statutory

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<sup>65</sup> as the decision in *Williams v R* (1986) 161 CLR 278 reveals.

<sup>66</sup> the difference between consent and informed consent is discussed *infra*, pp. 245-246.

<sup>67</sup> Bishop, *supra* note 2, at p. 64.

<sup>68</sup> Faden R., and Beauchamp, T., *A History and Theory of Informed Consent*, New York, Oxford University Press, 1986 at p. 121.

<sup>69</sup> (1973) 127 CLR 662 at p 663 per Menzies J.

conditions designed to regulate the collection of such evidence.<sup>70</sup> For example, in *Fullerton v Commissioner of Police*,<sup>71</sup> Lee J held that section 353A of the *Crimes Act* (1900) (NSW) was 'the sole source of authority ... the section will have application ... irrespective of whether the person in custody consents or does not consent to giving such particulars'.<sup>72</sup> In some jurisdictions, the statutes imply onerous requirements on the police. For example, in the Northern Territory consent to a medical examination is only lawful if the consent is in writing.<sup>73</sup>

### *Taking Samples without consent*

The taking of blood or other material from a person before his or her arrest without consent is a battery unless authorised by law.<sup>74</sup> There are limited examples where police can as of right demand that a person provide a sample to them. For example, legislation dealing with drink driving offences has been enacted in all States and Territories and empowers police to stop motorists suspected of driving under the influence or over prescribed alcohol limits. Such legislation empowers police to take breath and blood samples without consent (with the exception of Tasmania where they must be taken with consent).<sup>75</sup>

After arrest the common law gives the police the authority to search the person of someone in order to obtain relevant evidence. However,

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<sup>70</sup> Generally in all States and Territories of Australia legislation permits but regulates the collection of photographs, fingerprints and other bodily samples including, blood from a suspect or an accused person 'in custody' (S. 464 *Crimes Act* (1958)(Vic.); s. 353A *Crimes Act* (1900)(N.S.W.); s. 3-8 *Criminal Process (identification and Search Procedures) Act* (1976)(Tas.); s. 144-146 *Police Administration Act* (1978)(N.T.); s. 259 *Criminal Code* (1899) (Qld.); s. 236 *Criminal Code* (1913)(W.A.); s. 81 *Summary Offences Act* (1953)(S.A.) (formerly the *Police Offences Act* (1953)). These are general provisions which do not limit the taking of blood samples, for example, merely to criminal conduct involving alcohol or drugs.

<sup>71</sup> [1984 1 NSWLR 159.

<sup>72</sup> *Ibid*, at p. 163.

<sup>73</sup> s. 145(a) *Police Administration Act* (1978)(NT).

<sup>74</sup> Victorian legislation appears to authorise blood testing whether a person is in custody or not (*Crimes Act* s. 464A).

<sup>75</sup> s. 63-66 (breath and blood) *Road Traffic Act* (1974-1982) (W.A.); s. 7(breath), 10-13 (Blood) *Road Safety (Alcohol and Drugs) Act* (1970)(Tas.); s. 16A (breath and blood) *Traffic Act* (1949-1985) (Qld.); s. 53-55 (breath and blood) *Road Safety Act* (1986)(Vic.); s. 47e (breath), 47(i) (blood) *Road Traffic Act* (1961)(S.A.); s. 4E2A-15, *Road Traffic Act* (1909)(N.S.W.); s. 8D(breath), s. 8G (blood) *Traffic Act* (1949-1987)(N.T.); s. 9, 10, 15(4), 20(2) *Motor Traffic (Alcohol and Drugs) Act* (1977)(A.C.T.). Under these provisions there is no specific mention of the tests to which the blood taken may be subjected to.

as this power was based on the need to preserve evidence that is in danger of loss or destruction<sup>76</sup> it is not easy to see how blood is in such danger and accordingly it is arguable that the common law power to search to provide evidence does or should not apply to blood. Hence, the common law does not provide a solid foundation for police to take blood from an accused person for the purpose of obtaining evidence to substantiate an HIV transmission offence.

There is another way by which police could obtain such evidence. Police are empowered by statute to arrange for persons in custody to be examined by a medical practitioner.<sup>77</sup> The only restriction on their power in this regard, is that the police must believe that the examination is reasonably likely to reveal relevant evidence. This term 'medical examination' has also appeared in public health legislation. It has been stated in chapter five of this thesis that when the term 'medical examination' appears in legislation it is usually undefined. It is arguable that these words were intended to authorise no more than the physical observation of the condition of the detained person or subjecting the person to normal processes to determine his or her physical condition. This argument is supported by the fact that while it is part of normal medical practice to take a subject's blood pressure, it is not a normal medical procedure to take blood from an individual. The term itself does not on its face permit the removal of bodily material from a person. In only two States does the legislation specifically allow blood to be taken during a medical examination.<sup>78</sup>

The limited case-law in this area would support the view that the term 'medical examination' is to be given a wider interpretation than argued for above. Both *R v Harrison*<sup>79</sup> a Tasmanian case and *R v Franklin*<sup>80</sup> a

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<sup>76</sup> *Clarke v Bailey* (1933) 33 SR (NSW) 303 at p. 310.

<sup>77</sup> S. 464R *Crimes Act* (1958)(Vic.); s. 353A(2) *Crimes Act* (1900)(N.S.W.); s.6 *Criminal Process (identification and Search Procedures) Act* (1976)(Tas.); s. 145 *Police Administration Act* (1978)(N.T.); s. 259 *Criminal Code* (1899) (Qld.); s. 236 *Criminal Code* (1913)(W.A.); s. 81 (2) *Summary Offences Act* (1953)(S.A.).

<sup>78</sup> In Queensland, s. 259(3) of the *Criminal Code* and in Tas. s. 6(5) of the *Criminal Process (Identification and Search Procedures) Act* (1976). The Northern Territory legislation refers to a specimen being taken during an examination and having that specimen analysed (s. 145(3) *Police Administration Act*). Although it is not stated this could include blood. In 1990, section 145 was held to empower a Magistrate to order the taking of a blood sample if he or she is satisfied that the police have a reasonable belief that it might afford evidence relating to the offence *Galvin v R* (1983) 24 NTR 22. The Victorian provisions would also allow blood (an 'intimate sample' (s. 464(2))) to be taken as part of a 'forensic procedure' (s. 464(2)).

<sup>79</sup> (1915) Tas SR 140.

South Australian case established that taking blood is an 'examination'. Wells J held as to the meaning of 'medical examination':

it would in my opinion, be a mistake to suppose that it is confined to macroscopical or microscopical surveillance; the word is not so confined even in spheres of applied science outside medicine ... s. 81 contemplates ... the ascertainment of acts which may afford evidence relevant to the charge in question.<sup>81</sup>

Irrespective of these cases and the particular statutory provisions the question that needs to be answered is whether present legislation giving police the power to take bodily samples or subjecting a person to a medical examination, is wide enough to allow police and prosecutorial agencies to not only take blood from an accused person, but, then to arrange for that blood to be tested for HIV. There is no legislative provision which *specifically* provides that police are entitled to test blood samples taken from an accused for HIV antibodies. Therefore, there is at least, a rebuttable presumption that the test itself cannot be undertaken without consent of the accused and that police cannot authorise such tests.

It has been argued earlier in this thesis in chapters four and five, that the phrase 'medical examination' when contained in public health legislation would be unlikely to be held by a court to cover HIV testing. The accuracy of that view can now be considered in the context of the criminal process. In *Franklin*, the accused tried to argue that the forensic tests applied to a collection of blood and hair samples should not have been performed and that as a result evidence had been incorrectly admitted at his trial. The accused's argument was that the legislation required a doctor to conduct an examination and the laboratory technicians who applied tests to the blood were not doctors hence the legislation had been unlawfully obtained in breach of the procedural rules. In the context of deciding at what point a medical examination ended, the court stated that if blood is lawfully taken it is beside the point that it is analysed by another person and hence impliedly irrelevant that certain forensic tests are applied. It was thought that the laboratory testing was outside the protection of the section.

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<sup>80</sup> [1979] 1 A. Crim. R. 1.

<sup>81</sup> *Ibid*, at p. 5. King CJ and Leque J agreed with Wells J.

The decision in *Franklin* could be problematic for an HIV-infected person in South Australia who wants to prevent HIV tests being carried out on his or her blood samples. The Tasmanian decision of *Harrison* also tends to support the view in *Franklin*. However, both cases were decided before the advent of HIV/AIDS. The tests conducted in both cases were not of the nature of an HIV test. It is at least arguable that any precedent established would need to take into account that HIV testing is a procedure that has overwhelming social ramifications for the person tested. In the 1990 Northern Territory non-AIDS case of *R v Galvin*,<sup>82</sup> Muirhead J held that within the discretion of a Magistrate to order blood testing 'lies the protection to the individual from serious inroads into his physical well being'.<sup>83</sup> It could be argued that Muirhead J would decline to order an accused to undergo a blood test for HIV should the matter arise, given his statement in this case. In Wells J's judgment in *Franklin*, there is some indication of a similar view:

the limits of reasonableness [of the tests] may vary markedly and depend, upon such matters as the extent to which the examination will invade the integrity of the body, the state of health of the prisoner, the seriousness of the charge, and the cogency of the evidence that there are reasonable grounds for believing that the examination will afford.<sup>84</sup>

In the absence of any case-law on the matter of HIV testing in the criminal process in Australia the position in the United States can be considered. The United States Supreme Court has held in general that the removal of blood without consent is a search and seizure.<sup>85</sup> In order for the search to be constitutional it must be reasonable.<sup>86</sup> Generally to be

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<sup>82</sup> (1983) 24 NTR 22. It is significant however, that the Northern Territory legislation is the only legislation which contains a provision (s. 145(3)) which actually sets out that a specimen may be analysed. This could be relied on as providing the justification for an HIV test to be applied to a specimen.

<sup>83</sup> *Ibid*, at p. 26.

<sup>84</sup> *supra* note 80, at p. 5.

<sup>85</sup> *Schmerber v California*, 384 US 757, 767 (1966).

<sup>86</sup> This is provided by the Fourth amendment to the US Constitution:

the right of the people to be secure in their persons, houses, papers and effects, against unreasonable searches and seizures, shall not be violated, and no warrants shall issue, but upon probable cause supported by oath or affirmation, and particularly describe the place to be searched, and the person or things to be seized.

reasonable a search warrant and probable cause are required. However, where governmental interests present 'special needs [beyond those] of normal law enforcement' <sup>87</sup> a search may be reasonable in absence of these requirements. There is no US authority which specifically separates up for examination the issues of taking blood and then testing it. In *Johnetta v Municipal Court of California*, <sup>88</sup> the defendant challenged a California law that required mandatory AIDS testing for criminal defendants in biting cases. The court held that although the evidence of transmission from biting was low, because medical evidence was not really conclusive on the point, this uncertainty was enough to justify the search. <sup>89</sup> It is questionable whether the US Supreme Court would have found the testing scheme reasonable if this case had been appealed. It is likely that constitutional rights as to privacy would have been an important issue in the decision. The lack of such rights in Australia render comparison with the US of limited usefulness.

Therefore, it is instructive to turn to consider the issue of consent to HIV testing in situations outside the criminal process, for example, in the area of medical treatment. The application of these principles to the criminal sphere can then be considered. The matter of consent to HIV testing in the course of medical treatment has been debated at some length in the United Kingdom in the late 1980s. Leading commentators in the area have held that because of the nature of HIV testing and the ramifications that ensue following a positive result that consent to take blood does not extend to consent for that blood to be subjected to an HIV test. <sup>90</sup> This view, it is argued is supported by the principle of self-determination or autonomy as it is applied to medical treatment. <sup>91</sup>

It appears that the issue of consent is inextricably connected to the cause of action that one is seeking to establish; whether a person wishes to sue for a battery or in negligence. Legal authority supports the view if a

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<sup>87</sup> from *Skinner v Railway Labor Executives Association* 489 US 602 (1989).

<sup>88</sup> 267 Cal. Rptr. 666 (Cal. Ct. App. 1990).

<sup>89</sup> *Ibid.*, at p. 692.

<sup>90</sup> Kennedy and Grubb argue that the failure to obtain such consent gives rise to a valid claim both in battery and in negligence ('Testing for HIV infection: the legal framework' (1989) *Law Society Gazette*, 30 at p. 34-35). In Australia, Hamblin has stated that it is unlikely that a general consent to testing will cover HIV testing because of the nature of the HIV test (Hamblin, J., 'Health Care Rights and Responsibilities' (1992) *Law Society Journal*, 66-70 at p. 67).

<sup>91</sup> Faden and Beauchamp, *supra* note 68.

doctor fails to tell a patient of the broad nature of the treatment to be imposed he or she commits a battery for which he or she is liable to the patient in damages.<sup>92</sup> Liability arises irrespective of the fact that the treatment performed by the doctor is medically justified, proficiently performed and beneficial to the patient.<sup>93</sup> In the case of HIV and blood testing where a person consents to general blood testing, if the blood was tested for HIV without the specific consent of the individual concerned, an action in battery would not lie. However, where the action is in negligence, it is not sufficient if a person is told in broad terms what the treatment will entail. The person's consent must be an 'informed' one.<sup>94</sup> In 1992, the High Court of Australia in *Rogers v Whitaker*<sup>95</sup> handed down an instructive judgment on what is encompassed by this term 'informed consent'.<sup>96</sup> The court held

that the doctor has a duty to warn a patient of a 'material risk' inherent in the proposed treatment. A risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that a particular patient, if warned of the risk, would be likely to attach significance to it.<sup>97</sup>

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<sup>92</sup> *Chatterton v Gerson* [1981] 1 All ER 257 and confirmed in Australia by the High Court in *Rogers v Whitaker* (1992) 109 ALR 625, at p. 633 per Mason CJ, Brennan, Dawson, Toohey, McHugh and Gaudron JJ concurring.

<sup>93</sup> as shown in *Murray v McCurphy* [1949] 2 DLR 442.

<sup>94</sup> A detailed examination of informed consent to medical procedures is beyond the scope of this thesis, but is covered in detail in Australia in Manderson, D., 'Following Doctors' Orders: Informed Consent in Australia', *Australian Law Journal*, Vol. 62, 1990, 430-440; Monks, S., 'The concept of Informed Consent in the United States, Canada, England and Australia; A Comparative Analysis' (1993) 17 *University of Queensland Law Journal*, 222-233.; and in Canada by: Somerville, M., 'Structuring the Issues in Informed Consent' (1980) 26 *McGill Law Journal*, 1980, 738-808; Robertson, G., 'Informed Consent: ten years later; the impact of *Riebl v Hughes*' (1991) 70 *Canadian Bar Review* 423, 433.

<sup>95</sup> *supra* note 92.

<sup>96</sup> The phrase was 'born' in *Salgo v Leland Stanford University Board of Trustees* (1957) 317 P 2d 170. The court in *Rogers v Whitaker* (*supra* note 92), was fairly scathing of this American and somewhat 'amorphous phrase' 'informed consent' (at p.633).

<sup>97</sup> *supra* note 92 at p. 633-634. The court also held that the questions of informed consent do not depend solely on medical standards or practices. This marked a fundamental departure from the decision in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 where it was held that the test to be imposed was whether a doctor acted in accordance with a practice accepted as proper by a responsible body of medical practitioners skill in that particular art. The requirement that 'material risks' be disclosed is in accordance with US (*Canterbury v Spence* 464 F.2d 772 (D.C. 1972) at p. 784 and Canadian (*Riebl v Hughes* (1980) 114 DLR (3d) 1, at p.13 per Laskin CJC) authority.

This test can be translated to the issue of HIV testing. Although there is no case law on the issue, in Australian medical practice it is generally recognised that the HIV test should not be administered without the patient being advised of the social and medical ramifications of the test. The question is whether this is a merely an ethical and thus non-legally binding rule or whether it is a standard practice adopted by the profession. The latter may be relevant for purposes of a negligence claim. A person who is about to be tested for HIV would wish to know the medical and social and, in some circumstances, the legal effect of a positive result. Therefore, for the patient the outcome is significant in deciding whether or not to undergo the test.

As present pre-trial criminal procedure legislation in Australia does not specifically allow police to subject an accused's blood to HIV testing without his or her consent it is necessary to consider the application of general principles regarding consent and informed consent to this process. The principles will be considered in their application to certain factual situations involving testing which may occur during the pre-trial criminal processes. These situations may present themselves to a court in the future when the evidence obtained is challenged as being inadmissible. As an aside, these principles may also establish whether an accused person has grounds for a claim against police authorities in battery or negligence.<sup>98</sup> The six situations considered below raise three major issues: consent and capacity to consent; informed consent; and, fraud as to consent.

The first situation involves the police arranging for blood to be taken from A contrary to A's consent where there is no clear nexus between the need to obtain such information and the offence for which A is charged. For example, A has been charged for stealing rather than for resisting arrest by biting. The result is that the test is unlawful, the information unlawfully obtained and the doctor has committed an assault or battery which the police have instigated the doctor to commit. The unlawfulness may also be provided by the fact that there is a breach of a statutory provision. This would occur in the Northern Territory, for example, where legislation specifies that the written consent of the accused is required<sup>99</sup> and in other States where legislation

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<sup>98</sup> Causation and remoteness of damage would also need to be proved. These matters are not considered in this thesis since the resolution of whether an accused person should sue police is not the main thrust of this section.

<sup>99</sup> s.145(b) *Police Administration Act* (1978)(N.T.).



directs that upon refusal by the suspect a court order must be obtained to even take blood samples from the suspect.<sup>100</sup>

The second factual scenario, is where the doctor at the request of a police officer takes blood from A without A's consent while A is unconscious, and tests it for HIV infection. A falls into the category of an temporary incompetent patient. If testing is done for the purpose of providing police with some evidence then this is a non-therapeutic intervention. To carry out a such an intervention full disclosure is required.<sup>101</sup> The legality of the procedure will depend upon whether it is reasonable to obtain the sample and test it for HIV in the circumstances of the offence charged. The principle of necessity is an exception to the requirement to obtain consent and it applies in emergency situations.<sup>102</sup> As HIV status is not something capable of being destroyed over time an argument based on the necessity to prevent the destruction of evidence would not succeed. Even if there is a nexus, for example, that A has been charged for biting a police officer, if the testing could have been delayed until A could be advised that testing that was to take place and given a chance to consent to both the blood being drawn; the test being taken and to receive counselling, the taking of blood from an unconscious accused would not be justified.

The third factual situation is where the police ask A for a blood sample and A consents, but police then subject that blood to an HIV antibody test. Although in this example A has not been told his or her blood would be tested it may be argued that the testing for HIV antibodies is a mere extension of A's general consent. Further, it has been argued by one commentator that once the blood is taken from a person proprietary rights over the samples cease.<sup>103</sup> The English case of *Chatterton v Gerson*<sup>104</sup> provides a legal basis

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<sup>100</sup> This requirement is only specified under the Victorian S. 464T *Crimes Act* (1958)(Vic.) and s. 145(1)(b) *Police Administration Act* (1978)(N.T.); s. 259(4)(b) *Criminal Code* (1899) (Qld.) with 259(6) setting down the requirements police have to prove in order for a magistrate to make the order required. The other States do not set out that consent is required and allow samples to be taken by reasonable force: s. 353A *Crimes Act* (1900)(N.S.W.); ss. 6(5)(6) *Criminal Process (identification and Search Procedures) Act* (1976)(Tas.); s. 236 *Criminal Code* (1913)(W.A.); s. 81(2) *Summary Offences Act* (1953)(S.A.).

<sup>101</sup> Somerville, *supra* note 94 at p. 765.

<sup>102</sup> Monks, *supra* note 94, at p. 2.

<sup>103</sup> Langley QC for the Medical Defence Union, in MDU, 'AIDS *Medico-Legal Advice* London, MDU, 1988, 4-5.

<sup>104</sup> [1981] QB 432 and followed in Australia in *Rogers v Whitaker* *supra* note 92 at p. 633.

for implying consent for testing for HIV from a general consent for the blood to be taken so as to negative a battery. The cases of *Harrison* and *Franklin* <sup>105</sup> support the view that there is no restriction on the tests which can be conducted on that blood sample. In the final analysis, it may depend on whether the matter is being seen from the perspective of an action in battery or in negligence

If the circumstances are changed slightly to the situation where police have told the accused that they were going to subject his blood to routine tests, arguably the same issues just addressed arise. It has been argued that testing for HIV is seldom seen as routine. <sup>106</sup> It has been suggested that given the uniqueness of the ramifications of HIV testing perhaps it is of prime importance to consider whether A has, in fact, consented to a blood test for HIV infection. For example, Kennedy and Grubb <sup>107</sup> suggest that a court may believe it is contrary to public policy to regard consent to testing as including consent to a test which could have detrimental family and employment consequences for the accused. Only a full informed consent will render A's assent a valid consent. These authors would be correct in general terms if the cause of action being considered was negligence rather than a battery. The requirement of disclosing 'material risks' would mean that where HIV testing is conducted in the criminal process that the suspect must be told what use will be made of the test in future proceedings.

The fourth scenario involves circumstances where A consents to a blood test because he or she is told by police that such testing is routine for all suspects in order to ensure they are not HIV-infected. Although A has consented here and has been told that his or her blood will be tested for HIV, the consent given may be deemed invalid because police have led A to believe the testing is routine and A may therefore consent because he or she perceives it to be necessary. There is a subtle form of duress involved in this example which could render the consent one that was not freely and voluntarily given. Such involuntariness might also arise in a situation where a person was incapable of consenting because he or she was intoxicated and

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<sup>105</sup> *supra* notes 79-81

<sup>106</sup> Sherrand, M., 'Human Immunodeficiency virus antibody testing' *BMJ* 1984, 295:910 at p. 911-912 although it appears that such a view is insupportable by any established authority. It has also been held in the US: Gostin, L., 'Hospitals, Health Care Professionals, and AIDS: The Public's Perspective', *New Eng J Med*, 1988, 339: 9-43).

<sup>107</sup> *supra* note 90, at p. 35.

unable to make a rational decision. This situation would likely result in the evidence being regarded as unlawfully obtained.<sup>108</sup> The consent may also be ineffective because the assumption can be made that the blood is being tested for the protection of persons other than the accused. This raises the debate about the consent required for therapeutic versus non-therapeutic interventions. In Australia guidelines are in place that prevent surgeons from conducting HIV tests on prospective surgery patients merely for the doctor's protection.<sup>109</sup> Similarly, in Tasmania and Victoria, the legislature has seen fit to specifically provide for the circumstances under which an HIV test can be carried out on one person for the benefit of another.<sup>110</sup>

The fifth situation is where the police advise A that his blood is being taken to test it for Hepatitis B. The blood is tested for HIV and this was the intention of the police from the beginning. Here the police officer has acted in a fraudulent manner and the cause of action lies in battery.<sup>111</sup> Even if the doctor tests for Hepatitis B as well, this should not excuse the original fraudulent inducement. It is a positive deception calculated to obtain consent. The evidence would also be regarded as improperly obtained. However, in Australia following the High Court decision of *Papadimitropoulos v R*<sup>112</sup>, confirmed in 1991 by *Mobilio v R*<sup>113</sup>, as long as A knows the nature and character of the act he or she is consenting to, for example, an application of force, then the inducing cause (testing for Hepatitis B) is irrelevant. Although these are criminal assault cases, the rules governing consent in criminal law and in tort or battery are 'directly comparable'.<sup>114</sup> As argued in chapter three

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<sup>108</sup> Under section 145(11) of the *Police Administration Act* (1978)(N.T.), it is stated that 'nothing in this section shall ... affect the power of a court to exclude evidence obtained through force or inhumane treatment.' Hence the evidence could be rendered inadmissible.

<sup>109</sup> For example, although in 1991 the Australian Medical Association recommended pre-surgical testing, this has not been accepted in the A.C.T. (Commonwealth of Australia, *National HIV/AIDS Evaluation 1991-1992 State Stories Report*, Canberra, Australian Government Publishing Service, 1993, at p. 124). See also fn 111 chapter five.

<sup>110</sup> as discussed *supra* under section headed 'Testing the Accused to Reassure the Victim'.

<sup>111</sup> This is the difference between actions in battery and negligence in this area. The former are accompanied by intention whereas the latter are not (*Reibl v Hughes* (1980) 114 DLR (3d.) 1).

<sup>112</sup> This case was covered in some detail in chapter three, pp. 118-122.

<sup>113</sup> *Mobilio v R* (1990) 50 A. Crim. R. 170 (Vic. CCA) and (1990) 24 Leg. Rep. 14-15 (HC special leave applic.)

<sup>114</sup> Somerville, M., *supra* note 94, at p. 743. However, it must be noted that the law relating to fraud as to consent as it has evolved in the criminal law in Australia is not the same as the law in Canada on the same topic (see chapter three, where this point is debated at length, at footnote 131).

<sup>115</sup> of this thesis this rule which currently encourages deceptive practices requires re-consideration in light of HIV. The common-law interpretation of fraud is likely to be relevant to the interpretation of the term in statutes which allow evidence obtained by fraud to be excluded. <sup>116</sup>

However, if police extracted consent to testing on the *condition that* it was for Hepatitis B only then it is arguably outside the scope of A's consent for the police to test the blood for anything else. <sup>117</sup> Any other intervention not covered by express consent or implied by conduct would be unlawful unless justified on some other basis such as necessity. <sup>118</sup> This example can be more readily explained by considering the situation where A is detained for drink driving following a positive breath test and elects to have a blood test. If while subjecting that blood to a test for alcohol content the doctor at the request of the police also tests the accused's blood for HIV antibodies, this would be unlawful. A has not specifically consented to have his or her blood tested for HIV. In fact, A has elected to have his or her blood tested for alcohol content, so it could be argued that A has only one specific purpose in mind which is directly connected to what A is charged for; consent is *conditional* on the police performing the test he or she has contemplated. Any other test including an HIV test conducted in these circumstances is unlawful and the evidence would be unlawfully obtained. Somerville has suggested that 'certain matters require express consent'. <sup>119</sup> In the future, courts may regard HIV testing as such a matter. In resolving the dilemma, the purpose for which the test is taken would be significant. If the test is done for the benefit of the victim it would be unlikely to be regarded as justified. One ground that might be considered by a court in coming to this decision, is the fact that the legislature in two States of Australia has seen fit to specifically provide for circumstances where testing may be conducted for the benefit of another. However, if testing is for the purpose of obtaining evidence then the principles relevant to the discretion to exclude evidence would be relevant. These will be discussed in the next section.

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<sup>115</sup> Chapter three, pp. 118-122.

<sup>116</sup> Provisions such as s. 145(11) of the *Police Administration Act* (1978)(N.T.), *supra* note 108.

<sup>117</sup> Teff, H., 'Consent to Medical Procedures: Paternalism, Self-determination or therapeutic Alliance?' (1985) 101 *Law Quarterly Review*, 433 at p. 439.

<sup>118</sup> Somerville, *supra* note 94, at p. 788.

<sup>119</sup> *Ibid*, at p. 789.

The final situation involves a set of facts where the police tell A they want to take a blood sample from him or her and subject it to an HIV test which may in turn provide evidence capable of substantiating the charge against A. Where A is advised of the ramifications of a positive test result including the purpose for which the procedure is required; the nature of the procedure sought to be conducted; the offence for which the person is suspect of having committed or with which the person has been charged; that the procedure could produce evidence to be used in a court; and, that the person may refuse to undergo the procedure then informed consent has taken place and the consent to the test would be valid.<sup>120</sup> The evidence would be held to be lawfully obtained. It could be queried whether the other risks associated with a positive HIV antibody test result, such as social ostracism, breakdown of personal relationships and possible loss of employment, would need to be disclosed before the consent would be regarded as being fully 'informed'. It may be preferable for police to obtain written consent prior to testing which would indicate that the accused had been informed of the social, legal and ethical ramifications of testing.

Overall these scenarios involve two issues relating to testing within the criminal process. The first, is the issue of obtaining consent to take blood. A person must consent to that procedure or where the person refuses to consent, in some jurisdictions a court order must be obtained.<sup>121</sup> The second issue, whether specific consent is then needed to test that blood for HIV, is fraught with uncertainty and the resolution of the matter is dependent upon a consideration of the whole circumstances under which such testing is conducted. The general rules relating to consent and informed consent to medical interventions will be applicable to HIV testing of persons in custody unless exceptions are provided by statute. The common law and statutes relating to blood sampling merely allow blood to be taken. When it is to be taken without consent some statutes dictate that a court order is to be obtained. None of these statutes authorise that such blood samples can be subjected to any test. Arguably there is not much point in legislation authorising the mere collection of blood. Where a court order is required for

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<sup>120</sup> Such are the examples of what is required for informed consent in the Victorian legislation, s. 464S of the *Crimes Act* as amended in 1993.

<sup>121</sup> In those where it is not, it appears that the test could be taken by 'reasonable force' (s. 236 *Criminal Code* (1913)(WA); s. 81(2); *Summary Offences Act* (1953)(S.A.); s. 6(6) *Criminal Process (Identification and Search Procedures) Act* (1976)(Tas.). Under s. 145(4) of the *Police Administration Act* (1978)(N.T.) reasonable force may be used to obtain a sample after the taking of the sample has been authorised by a Magistrate under s. 145(1)(b).

the initial blood sample to be taken, HIV testing could be specifically requested at that time. Unless the purpose of testing is for the benefit of another person rather than the prosecution of crime, it is difficult to see how such testing could be denied unless the ramifications of HIV tests as opposed to any other test are seen to override the interests of the police being able to solve crime. If procedural safeguards are in place which mandate counselling and information to be provided to the accused about the likely use of the test results (whether it be any test), then HIV testing may be more acceptable. The diversity of the views on the point in the medical arena provide strong grounds for the matter to be legislated on specifically in the criminal law sphere.

Before concluding, however, it is useful to have recourse to the legal situation of DNA testing in Australia. This form of testing, also known as genetic fingerprinting, has been found to be of value in establishing paternity, indicating a family linkage and more recently in identifying the perpetrators of crime.<sup>122</sup> The results of DNA testing have been admitted into evidence in trials in some Australian States.<sup>123</sup> This is significant because DNA testing does not have the same level of accuracy and reliability as HIV testing.<sup>124</sup> It is also relevant that there is no specific legislation authorising such tests to be done. In fact, in *Tran*<sup>125</sup> although the evidence was not admitted, there was no discussion as to whether police should have permitted the blood samples to be tested for DNA. It seems to be assumed by the Judge that the procedure was an accepted one.

The Victorian *Crimes Act* (1958) was amended in 1990 and refined further in 1993 by inserting a new section 464, which was enacted to provide

<sup>122</sup> White, R. M., and Greenwood, J. J. D., 'DNA Fingerprinting and the Law' (1988) 51 *Modern Law Review*, 145.

<sup>123</sup> In *R v Joseph and Kelly* unreported judgment of the Supreme Court of W. A., Wallace J in admitting results as evidence acknowledged the validity of the process (Personal correspondence, G. Tannin, Crown Prosecutor, W.A. DPP). The evidence was also admitted in *R v Green* unreported judgment of the New South Wales Supreme Court, March 26 1993. Other cases where the matter was debated but the evidence was not admitted include: *R v Van Hung Tran* (1990) 50 A. Crim. R. 233 per McInerney J and *R v Lucas* unreported case 70154/89 Vic. Supreme Court per Hunt J.

<sup>124</sup> The unreliability of the expert evidence in relation to DNA matching was instrumental in the decision in *Tran*, *Ibid.* Procedures involved in matching bands have not been accepted by a clear majority in the medical community. There is no consensus on the procedures to preserve the integrity of the testing and no consensus on the statistical exposition that can be derived from matching DNA samples (Brodsky, G., 'DNA: the Technology of the Future is Here' (1993) *Criminal Law Quarterly*, 10-39, at p.1, 36).

<sup>125</sup> *Ibid.*

for (DeoxyriboNucleic Acid) DNA testing <sup>126</sup> although such a purpose is not clearly set out in the provisions. The procedural safeguards <sup>127</sup> in place in the statute are very detailed and if they are followed in any given situation then any loss of individual rights will be far outweighed by the advantages of either identifying the suspect as being involved in the commission of an offence or eliminating that suspect from suspicion at an early stage. For example, a person's consent to having a forensic procedure performed on him or her is not valid unless the consent is fully informed. Informed consent is defined in section 464S. <sup>128</sup> The Act also sets down a detailed procedure for application to a Magistrate where a person refuses to provide intimate samples (including blood). It has been argued that the terminology in the Victorian legislation could by extension authorise HIV testing in the future. <sup>129</sup> However, the fact that Victoria has recently enacted specific legislation empowering tests to be conducted where a custodian could have been exposed to HIV infection as a result of an incident occurring <sup>130</sup> would indicate that the matter requires specific legislative intention.

In conclusion, the analysis of the hypothetical situations raised in this chapter reveal that there is an uncertainty with respect to the legality of testing persons in custody for HIV. It is timely for the legislature to bring some certainty to the law and consistently between jurisdictions. As an example of the latter point, in Victoria, by virtue of the 1993 amendments to the *Crimes Act*, if blood is subjected to an HIV test and the suspect was not informed of the purpose to which the results of such a test might be put, then such evidence might be regarded as unlawfully obtained. In addition, where a refusal to consent was not followed up by a court-order then the evidence may also be rendered inadmissible in any subsequent trial. By contrast, the

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<sup>126</sup> Freckleton, I., 'DNA Profiling: Forensic Science under the Microscope' (1990) 14 *Criminal Law Journal*, 23-41.

<sup>127</sup> Section 464 allows police to request a person (over 17 years) suspected of committing an indictable offence which would include murder, manslaughter, sexual offence and assault, to provide a sample of blood. Under section 464(R) there must be reasonable grounds to believe that the taking of a sample would tend to confirm or disprove the involvement of the suspect in the indictable offence. If a person refuses to give consent to testing, an application can be made to a Magistrate under section 464(T) for an order to obtain a blood sample.

<sup>128</sup> and was outlined earlier, *supra* note 120.

<sup>129</sup> See commentary on legislation in Freckleton, *supra* note 126.

<sup>130</sup> under the *Health (Infectious Diseases) Act* (1991). The provisions of this Act were considered *supra*: 'Testing the Accused to Reassure the Victim'.

Tasmanian *HIV/AIDS Preventative Measures Act* <sup>131</sup> may permit blood that is taken from an accused with consent or without consent (where a court order is obtained) to be tested for HIV. There is no mention of the accused's informed consent being obtained. In other jurisdictions there is no reference to the necessity to obtain a court order for even blood to be taken let alone a HIV test being conducted. In fact, the statutes authorise such samples to be taken by reasonable force. <sup>132</sup> In these circumstances, the only protection left is for the court to render the evidence inadmissible because the prejudicial effect outweighs the probative value. This issue requires examination.

*Will unlawfully or unfairly obtained evidence be admissible in court?*

Even if the evidence is unlawfully or unfairly obtained in the manner described in one of the scenarios discussed above or through a failure to adhere to the legislative procedure for taking samples it may still be held to be admissible evidence at the accused's trial. The English view prior to the enactment of the *Police and Criminal Evidence Act* (1984) was to admit all relevant evidence irrespective of how it has been obtained. <sup>133</sup> In Australia where the law is based on the common law of England the courts, while not adopting a view as liberal as England, have not been as rigid as United States courts, which adhere to the exclusionary rule of evidence from illegal searches. <sup>134</sup> The leading precedent in Australia is *R v Ireland* <sup>135</sup> which concerned a suspect who had been subjected to a medical examination while in police custody under section 81 of the *Police Offences Act* (1953)(S.A.) without being told of his right to have a doctor of his choice present. *Ireland*

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<sup>131</sup> Section 14(1) of the *HIV/AIDS Preventative Measures Act* (1993)(Tas.) in fact refers to the need for pre-test counselling during which a person should be advised of the 'medical and social consequences of being tested'. As this provision will be relevant to the HIV testing a suspect of a sexual offence under s. 10(1), section 14(1) should be amended to read 'medical, social and legal consequences of being tested'.

<sup>132</sup> *supra* note 100.

<sup>133</sup> *R v Sang* [1980] AC 402. Zander provides convincing evidence that the position in England has changed markedly since the introduction of the legislation. There are many cases where evidence has been excluded on the basis of a failure to comply with provisions of either the Act or the Codes of Practice annexed to the Act (Zander, M., *The Police and Criminal Evidence Act 1984*, 2nd ed, London, Sweet and Maxwell, 1990, at pp. 202-208).

<sup>134</sup> *Mapp v Ohio* 367 US 643, at p. 656 (1961).

<sup>135</sup> (1970) 126 CLR 321.



established a discretion in the Judge whether to admit or reject the evidence. Barwick CJ's judgment in *Ireland* clearly puts the terms of this discretion.

Evidence of relevant facts or things ascertained or procured by means of unlawful or unfair acts is not, for that reason alone, inadmissible. This is so, in my opinion, whether the unlawfulness derives from the common law or from statute. But it may be that acts in breach of a statute would more readily warrant the rejection of the evidence as a matter of discretion: or the statute may on its proper construction itself impliedly forbid the use of facts or things obtained or procured in breach of its terms. On the other hand evidence of facts or things so ascertained or procured is not necessarily to be admitted, ignoring the unlawful or unfair quality of the acts by which the facts sought to be evidenced were ascertained or procured. Whenever such unlawfulness or unfairness appears, the judge has a discretion to reject the evidence. He must consider its exercise. In the exercise of it, the competing public requirements must be considered and weighed against each other. On the one hand there is the public need to bring to conviction those who commit criminal offences. On the other hand there is the public interest in the protection of the individual from unlawful and unfair treatment. Convictions obtained by the aid of unlawful or unfair acts may be obtained at too high a price. Hence the judicial discretion.

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In *Ireland* Barwick CJ considered that section 81 imposed specific conditions on police for making suspects submit to medical examinations. Such provisions he thought were obviously enacted for the protection of the person arrested. As these conditions were not observed in the case the discretion was to be exercised by rejecting the evidence.<sup>137</sup>

In the later case of *Bunning v Cross*<sup>138</sup> the High Court held that this passage of the Chief Justice represented the law in Australia. In this case the court had to decide whether to exclude evidence obtained in a breathalyser test which had been administered in contravention of the statutory requirements. It spelt out the guidelines for judicial exercise of the discretion laid down in *Ireland*. The evidence was admitted on the ground that the unlawful conduct of the patrolmen had been a mistake and not a

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<sup>136</sup> per Barwick CJ in *R v Ireland*, *Ibid* at p. 355 a passage quoted in *Bunning v Cross* (1978) 141 CLR 54 (at p. 72) as representing the law in Australia and later held to apply to confessional evidence in *Cleland v R* (1982) 151 CLR 1.

<sup>137</sup> *Ibid*, at p. 344.

<sup>138</sup> (1978) 141 CLR 54.

deliberate or reckless disregard of the law. From the judgment of the court it can be seen that unfairness to the accused is not an overriding consideration in the exercise of the discretion. It involves a weighing of the necessity of bringing a wrongdoer to trial with the need to prevent the unlawful conduct of those who enforce the law. The discretion will only come into operation when the evidence is the product of unfair or unlawful conduct on behalf of those who enforce the law.<sup>139</sup> The authorities on the admissibility of real evidence procured in consequence of an illegal search tend to be in favour of its admission.<sup>140</sup> Many of the cases were decided before *Bunning v Cross* and hence the *Ireland* discretion would now need to be considered by a court.

The matter of unfairly or unlawfully obtained evidence could well arise in the context where the HIV status of the accused is directly relevant to the offence and police have sought to obtain evidence to substantiate the charge through a blood test, without the consent of the accused. It is unclear whether courts will be moved to exclude the evidence of HIV on the basis of breaches in the procedures for the extraction of samples from detainees, for example, where a court order to obtain blood was not applied for. However, factors which may weigh in favour of exclusion could be that the offence in question is a minor one, and that improper police conduct was serious (rather than technical), intentional (rather than made in good faith<sup>141</sup>) and common practice (rather than an isolated matter not calling for deterrent intervention by the courts.<sup>142</sup> Where the legislation is unclear as to whether blood samples may be tested for HIV, the police could rely on mistake. Unless their conduct 'involves an overt act of defiance of the will of the legislature'<sup>143</sup> then the evidence will not be excluded. The court would have to weigh the competing public requirements that may require that persons suspected of or suffering from HIV in the community be identified. As concepts of fairness have little priority in this discretion, the fact that an accused might argue it is unfair that

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<sup>139</sup> *Bunning v Cross* *ibid* per Stephen and Aickin JJ, at pp. 74, 75. Their Honours judgment has been followed in the 1990s, for example, *Brain v Froude* (1992) 63 A. Crim. R. 9; *Foster v R* (1993) ALJR 550.

<sup>140</sup> Byrne and Heydon, *supra* note 55 at p. 700.

<sup>141</sup> For example, cases have supported the view that where evidence is obtained by threats, false representations, tricks or bribes that the discretion will be exercised in favour of the defence (*R v Haas* [1972] NSWLR 589 at p. 593; *R v Carr* [1972] 1 NSWLR 608 at p. 611).

<sup>142</sup> These factors were referred to in the non-AIDS related case of *Cleland v R* *supra* note 136, at 16-17 and 34-35.

<sup>143</sup> *Bunning v Cross*, *supra* note 138 per Stephen and Aickin JJ, at p. 78.

his or her HIV test result is admitted into evidence may be of little relevance if the evidence has strong probative value and the competing public policy requirements favour its introduction.

The question that might arise is what would be the effect of paragraph 5.2.14 of the *National HIV/AIDS Strategy* on the relevant court. The Strategy has expressly set out the situations in which an accused person should be tested. These situations include, where a person is charged with a sexual offence where the test is requested by the victim of the alleged offence or his or her guardian. It is suggested that an order must be obtained from the court before police can proceed. The Strategy contains guidelines which have no binding force. However, if police abided by this guideline there would be no unlawfully obtained evidence. If the guideline is given statutory effect, then in Barwick CJ's view, if the police fail to obtain a testing order, the statute has been contravened and this would more readily warrant the rejection of the evidence as a matter of discretion. This would not tie the hands of the judiciary to act in A's favour because of the existence of the discretion. In order for police and courts to act with any degree of certainty and for the accused not to be subjected to unnecessary procedures, any future provision relating to HIV testing in the area of criminal pre-trial processes should, like the Victorian legislation, set out the procedure to be adopted in such cases.

### **3. TRIAL PROCEDURES: THE DEFENDANT AND THE VICTIM**

#### APPLICATION FOR A SPEEDY TRIAL

There are a number of procedures that might be implemented either at the request of the accused or the victim during the trial phase that have specific relevance to an HIV-infected person. These include a application a for speedy trial, an application to maintain the confidentiality of the accused and/or the victim. There is also another feature of the trial process that requires consideration in the context of an HIV-infected convicted person. The traditional goals of sentencing and their application to an HIV-infected person warrant examination.

Delays may be experienced in AIDS-related litigation because of the nature of HIV-infection. The long incubation period and the length of the 'window period' between the time of infection and the emergence of antibodies to the virus have the potential to delay the investigative process being set in motion. Technically, for more serious offences there is no limitation period within which charges should be laid. Leaving aside the

practical problems of proof, a person could be charged with attempted murder ten years after the period when the conduct transmitting the disease was inflicted. It is possible that it may take as long as ten years for the victim to become symptomatic. The concern of HIV-infected persons being able to withstand trial has already surfaced in one civil action in New South Wales. In that case, the Supreme Court granted an expedited hearing on the basis that continued delay might negate any benefit to which the HIV-infected plaintiff may be entitled. This followed evidence from the plaintiff's doctor that his or her patient might not be able to withstand cross-examination in due course.

<sup>144</sup> Where the case is known to be a sensitive one and the victim may be in a distressed or vulnerable state, the case should wherever possible be given a fixed date for hearing.

Any delay in the commencement of criminal processes may result in unfair trials. Witnesses' memories fade, offenders may abscond or re-offend and relevant evidence may become lost. In the AIDS context the situation is more perilous since either the victim or the accused could have died. Further, the relevant evidence is likely to be testimonial and forensic rather than documentary. Documentary evidence can still maintain its reliability after long periods of delay but forensic and testimonial evidence cannot.

The issue of delay in criminal proceedings was most recently considered by the High Court in *Jago v District Court* <sup>145</sup> a non-AIDS case, but one in which the principle to be gleaned from the decision is of relevance to any HIV-related matter. Jago had committed offences between 1976 and 1979, was arrested in 1981, and committed for trial in 1982. But the case was not heard until February 1987. He had not suffered any particular prejudice; in fact, he had acquiesced in the delay. The court rejected his application for a stay of proceedings. The issue of a right to a speedy trial was also considered. The court decided that although a common law right to a speedy trial had been recognised, <sup>146</sup> the right had not been recognised in any Australian or English case or held to be enforceable through a stay of

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<sup>144</sup> Patterson, D., Anderson, A., Hirsch, D., 'Fast-track hearing for AIDS plaintiff' (1991) *National AIDS Bulletin*, 36.

<sup>145</sup> (1989) 63 ALJR 640.

<sup>146</sup> citing McHugh J. A in *Herron v McGregor* (1986) 6 NSWLR 246.

proceedings.<sup>147</sup> Further, their Honours believed that they had no common law power to terminate proceedings on indictment.

However, their Honours did hold that courts have a general power to prevent unfairness to the accused and that the right to receive a fair trial was an entrenched right in the Australian legal system. It may be that the issue of delay could be considered as a ground of unfairness in this manner. All members of the High Court believed that a Judge could make an order expediting the trial. The majority<sup>148</sup> agreed that only in an exceptional case should proceedings be brought to a permanent halt. Mason CJ expressed the view that there should be a balancing process which allows for both the interests of the accused and those of the community in bringing criminals to justice to be taken into account.<sup>149</sup>

The case reveals that a stay is not the only response to unreasonable delay and any delay which undermines the accused's right to a fair trial warrants some form of action by the judiciary. The Court also set down the factors to be considered when deciding if the delay warrants a stay. These include, the length of the delay, the reason for the delay,<sup>150</sup> the extent of the accused's assertion of his or her right to a speedy trial, the prejudice to the accused and the public's interest in the outcome of the case. The court in *Jago* held that the accused must be able to point to proof of actual disadvantage, not just an inference or presumption of prejudice. Death of witnesses has been held to be prejudicial for an accused<sup>151</sup> as has the length of pre-trial incarceration.<sup>152</sup>

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<sup>147</sup> per Mason CJ. at p. 644. Article 14(3)(c) of the *International Covenant on Civil and Political Rights* (1975) provides for the right of an accused 'to be tried without undue delay'. Although ratified by Australia the terms of the covenant have no effect until accepted into domestic law by a statute. Further, in the United States the Sixth amendment to the US Constitution promises that 'in all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial.' Victoria is the one Australian State with speedy trial legislation. Under this legislation a trial must take place within eighteen months of the accused being directed to stand following a committal proceeding. Extensions of time can be granted though the *Crimes Act* (1958)(Vic.) s. 353(2)(3), and *Crimes (Procedures) Regulations* (1984).

<sup>148</sup> *supra* note 145, per Mason CJ, Toohey, J and Gaudron J and Deane J (if continuation would be oppressive).

<sup>149</sup> *supra* note 145, p. 642-3 and 644 respectively.

<sup>150</sup> Normal court delays due to backlog of cases, over-use of courts would not be a ground on its own for delay. In this respect the Supreme Court of Western Australia has recently indicated that there is no undue delay in obtaining dates for criminal trials and that priority is given to the listing of criminal trials where the accused is in custody. (Correspondence: 'Reasons for court delays', *West Australian*, May 16 1991, p. 51.) In many instances delay can be due to both administrative processes and the defendant.

<sup>151</sup> *Carver v Attorney General (N.S.W.)* (1987) 29 A. Crim. R. 456, at p. 463.

In the context of an HIV-infected person, the prejudice can be more readily shown. There are numerous studies that indicate the deleterious effects of incarceration on the health of an HIV-infected person.<sup>153</sup> A delay prior to the commencement of the trial for an HIV-infected person could be catastrophic for the prosecution given that any HIV-infected witnesses might have died.<sup>154</sup> As the delay continues there may be heightened problems of proving that A in fact infected B in a transmission type offence charge. A prosecution relating to HIV transmission made a long time after the commission of the crime and allegedly for reasons of public pressure may also be scrutinised by the court and a stay awarded. Again in the instance of an HIV-infected person the health and fitness of the accused to stand trial after this time period would have to be weighed against the community's interest in seeing justice done.

The High Court has held that if the original delay was not actuated by the bad faith of the prosecution, the psychological and sociological effects on the accused cannot be asserted as alone warranting a stay. These factors might only warrant other remedies, for example, an expedited trial. The High Court has expressed the view that the level of actual prejudice must be substantial so that '... nothing that a trial judge can do in the conduct of the trial can relieve against its unfair consequences'.<sup>155</sup> Hence in the context of an HIV-infected person health reasons alone may not be a sufficient ground for a stay being awarded. It has been argued by Fox that the *Jago* decision is a conservative one, and that in the past a sensitivity to unfairness had been growing, so that in many jurisdictions trials did not proceed on the grounds of delay simpliciter.<sup>156</sup>

Some statutory amendments have been introduced to public health legislation in recognition of the fact that delays could be serious to an HIV-

<sup>152</sup> *Barker v Wingo* 407 US 514 (1972).

<sup>153</sup> These studies are considered in chapter seven, footnote 117 and text.

<sup>154</sup> This matter has clearly been problematic in practice in Australia, for example, the attempted murder charge in relation to the stabbing of a prison warder at Long Bay Jail which was dropped when the prisoner died (chapter three, footnote 114) and in Canada, see for example, the *Ssenyonga* case (chapter three, footnote 139).

<sup>155</sup> per Wilson J in *Barton v R* (1980) 147 CLR 75, at p. 111.

<sup>156</sup> Fox, R. G., 'Criminal Delay as Abuse of Process' (1990) 16(1) *Monash University Law Review*, 64-90, at p. 89.

infected person. This legislation in New South Wales and Victoria allows for urgent appeals on detention orders. <sup>157</sup>

### THE MAINTENANCE OF PRIVACY IN THE COURTROOM

There are a number of ways in which both the accused's and the victim's privacy, particularly in relation to his or her HIV-infected status, can be protected within the courtroom. These will be considered.

#### (i) Divulging Confidential Information in Court

If the accused's HIV status is not directly relevant to establishing his or her criminal liability then there is no reason for it to be revealed in court. It may be that the HIV-infected status of A will be relevant to sentencing proceedings. This issue is addressed later in this chapter. An HIV-infected person who divulges confidential information to his or her doctor or a public health official is not protected against such information being later revealed by these persons in criminal proceedings. Although doctors are under a general ethical and legal obligation not to reveal confidential medical information <sup>158</sup> they are not obliged to maintain confidences in the face of a court order <sup>159</sup> or legislation requiring disclosure. There are provisions which require doctors to notify cases of AIDS or HIV to public health authorities. Such legislation does not mandate disclosures in other proceedings. <sup>160</sup> In addition, a public interest exception has also developed. <sup>161</sup>

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<sup>157</sup> s. 122(5) *Health Act* (1958) (Vic.); s. 25 *Public Health Act* (1991)(N.S.W.).

<sup>158</sup> the duty is maintained by the Hippocratic Oath contained in Australian Medical Association, *Code of Medical Ethics* (1989) 6.1.1, 6.2.1 is supported by the law of contract (*W v Edgell* [1990] 2 WLR 471 and in tort *Furniss v Fitchett* (1958) NZLR 396). It is also protected by the equitable duty to maintain confidences: *AG v Guardian Newspapers* (No. 2) [1988] 3 WLR 776.

<sup>159</sup> the Medical Defence Union lists this as a recognised exception to the duty of confidentiality: Lilienthal, C., 'Medical Confidentiality' (1994) 8(1) *Journal of the Medical Defence Union*, 6-7.

<sup>160</sup> Such as compulsory notification provisions relating to disease which are discussed in chapter five, fn 11.

<sup>161</sup> This exception is discussed *infra*.

The common law does not recognise an evidentiary privilege between doctor and patient.<sup>162</sup> In Tasmania, Victoria and the Northern Territory confidential information about an HIV-infected person may be protected under the doctor-patient privilege principles developed by statute.<sup>163</sup> These privilege principles prevent persons in confidential relationships from releasing information. The privilege is based on the premise that the confidential relationship between these parties outweighs the litigants' and the judicial system's needs and rights. However the legislation only protects parties to civil proceedings in this manner. In a 1991 Western Australian Law Reform Commission report on the privilege, no suggestion is made for it to be extended to criminal cases.<sup>164</sup>

Therefore, doctors may have to give evidence as requested in the criminal court even if it results in an infected person being identified. Further, a doctor may not rely on confidentiality as the ground for failing to report an offence that comes to his or her attention. In *Brown v Brookes*<sup>165</sup> the New South Wales Supreme Court held that it was contrary to public policy to enforce a right of confidentiality that would impede the investigation of crime. Hence a doctor who is taken in to the confidence of a person who admits or the doctor reasonably believes is acting in a manner which may place the community at risk for transmission of HIV, the doctor should disclose this information to public health authorities at least.<sup>166</sup>

In 1992 the issue of whether a medical witness could divulge information that would serve to identify an HIV-infected person in court was contested in the civil case of *PQ v Australian Red Cross Society*.<sup>167</sup> The question turned on the scope of section 141 of the *Health Services Act* (1988)(Vic.). McGarvie J held that section 141 precluded a witness from giving any information acquired by reason of his being an employee doctor of

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<sup>162</sup> *Duchess of Kingston's Trial* (1776) 20 How St T. 573.

<sup>163</sup> s. 28(2)(3)(4)(5) *Evidence Act* (1958)(Vic.); s. 96(2)(3) *Evidence Act* (1910)(Tas.); s. 12 *Evidence Act* (1939)(N.T.). However, where the matter which is being heard arises out of Commonwealth law, the privilege under State legislation cannot be relied on: *Hill v Minister for Health and Community Services* (1991) 30 FCR 272.

<sup>164</sup> WALRC, *Professional Privilege for Confidential Communications*, Project No. 90, Perth, WA, December 1991.

<sup>165</sup> unreported judgment of Supreme Court of New South Wales, August 18 1988.

<sup>166</sup> the duty to warn which also arises in this context is covered in detail in chapter seven, pp. 332-334.

<sup>167</sup> [1992] 1 VR 19.



a hospital, if a patient could be identified by the information. He decided that he would not give section 141 a wide construction in order to assist with the conduct of litigation. He said the section 'reflects an important social policy which the legislature has adopted to preserve confidentiality'.<sup>168</sup> This indicates that irrespective of the absence of privilege protections other legislation may contain safeguards against breaches of confidentiality by health personnel. This of course will only serve to protect HIV-infected persons in Victoria. In addition, the case did not concern a criminal prosecution,<sup>169</sup> and other public interest requirements may have overriding roles.

Australian jurisdictions may need to consider instituting rules of evidence that protect against confidential information that passes between doctors and public health officials and their patients being presented in criminal proceedings. However, the W.A. Law Reform Commission Report states that the Commission is 'unaware of any relevant studies into the extent to which preservation of doctor-patient confidentiality affects the willingness of individuals to seek medical help or to provide certain personal or sensitive information to doctors.'<sup>170</sup> If that is correct, until such information is forthcoming a privilege applied to the relationship between a doctor and his or her patient in the context of HIV/AIDS is unlikely to be considered. In that event, while the theory behind preventing the protection of such communications is that privileges deprive courts of material evidence, there is a need to consider other ways in which such evidence might be tendered which will not result in harm ensuing to the accused, the victim and their respective families. Different rules apply to the situation where the accused has discussed his or her HIV infection with legal counsel in the context of the pending case. In this situation the information is protected by legal professional privilege which is recognised in all Australian States and Territories by virtue of the common law rule laid down in *Grant v Downs*.<sup>171</sup>

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<sup>168</sup> *Ibid*, at p. 25.

<sup>169</sup> This matter arose directly for consideration under the same legislation in *Royal Melbourne Hospital v Matthews and Ors* (1993) 1 VR 665. Here the court held that the hospital had to deliver up medical records relevant to an HIV-infected person who had been charged under the criminal provision relating to reckless endangerment under s. 22 of the *Crimes Act*, pursuant to a police warrant issued in accordance with s. 465 of the *Crimes Act*. The police power overrode the confidentiality protection contained in s 141.

<sup>170</sup> *supra* note 164, at para. 5.16, at p. 70.

<sup>171</sup> (1979) 135 CLR 674.

A's lawyer may not be called to give evidence of information pertaining to A's infected status if it was communicated to the lawyer for the purpose of obtaining advice for pending or contemplated litigation. However the privilege does not prevent the disclosure of facts: it only applies to communications.

There is a need to consider the manner in which information could be brought to the attention of a judge when relevant to the proceedings, without it being stated in open court. Handing up a medical report which refers to the illness rather than announcing it to a crowded court room would be preferable. Pre-trial rules in a number of States already make provision for certain matters to be regarded as proven prior to the proceedings to obviate the need to present the material in court.<sup>172</sup> Similar issues arise when it is the victim who has to admit his or her HIV status. Victim impact statements are already part of some State court processes.<sup>173</sup> Information regarding the victim's confirmed HIV status could be included in such a statement. Arguments concerning the accuracy of material in such a report could result in a need to cross-examine the victim. In that case the court could be closed.

Indeed, instead of preventing a suspect, accused or witness from revealing information that might identify an HIV-infected person to their detriment, judges could order that courts be closed and issue suppression orders. These procedures will be considered.

## (ii) Closed Courts

Under New South Wales Public Health legislation proceedings for transmission offences are to be heard in the absence of the public.<sup>174</sup>

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<sup>172</sup> Rule 11 *District Criminal Court Rules* (1986)(S.A.) allows for a pre-trial Conference. Under Rule 13 the matters that may be discussed at such a meeting include the estimated length of time of the trial and ensuring the matter will be conducted in an expeditious and fair manner. Rule 14 sets out that parties can come to an agreement that a specified fact may be proved in a specified manner, a specified fact may be treated as established without proof or specified evidence may be read or a statement tendered without a witness being called. The *Supreme Court Rules* (1981)(S.A.) has similar terms. The *District Court Rules* (1973)(N.S.W.) also provide for similar matters to be discussed in pre-trial applications (r. 10). Section 5 of the *Crimes (Criminal Trials) Act* (1993)(Vic.) states that 'courts may determine certain matters about the form of giving evidence'.

<sup>173</sup> s. 301 *Criminal Law Consolidation Act* (1935)(S.A.) which was repealed in 1988 and replaced as s. 7 in the *Criminal Law (Sentencing) Act* (1988). This procedure is also available in New South Wales under s. 447C of the *Crimes Act* (1900).

<sup>174</sup> s. 37 *Public Health Act* (1991)(N.S.W.). In AIDS-specific public health amendments in 1988 in Queensland section 48 of the *Health Act Amendment Act* which penalised knowing transmission of HIV/AIDS, contained sub-section 48(3) which mandated that proceedings for transmission offences 'shall be heard in camera'. Section 21(7) of the Tasmanian *HIV/AIDS Preventative Measures Act* also requires that proceedings under the section (which deal with

Proceedings involving the application for a public health order on grounds that an infected person is endangering or likely to endanger the health of the public are to be open unless an objection is made on behalf of a party to those proceedings.<sup>175</sup> The person appealing against the provisions of the public health order has the onus of overturning the requirement that proceedings be heard in public. Under section 77A of the *Crimes Act* (1900)(N.S.W.), proceedings can be held in camera. This provision could be used in an HIV-related criminal prosecution although it presently specifically applies to certain sexual offences and child prostitution offences.

In Victoria, by comparison, the court has power to close proceedings or restrict the audience if the social and economic consequences are such that the disclosure of the evidence would have deleterious effects.<sup>176</sup> Under Victorian public health legislation protection of privacy is an overriding concern.<sup>177</sup> In 1994 the phrase social and economic consequences was considered in relation to an HIV-infected prostitute charged with loitering in *Herald & Weekly Times v Braun and Ors*.<sup>178</sup> The Court concluded that social consequences could include the stigma that may attach to a person if it became known that he or she is infected with HIV; the stress or anxiety which may be caused to a person if the fact that he or she is infected with HIV becomes known the public at large, the fact that death may be hastened in the event that that occurs and the fact that a person infected with HIV may be unlawfully discriminated against if it becomes public knowledge that the or she is so infected.

In addition to powers under public health legislation, provision is made in Evidence Acts in some jurisdictions for courts to be cleared or closed. For example, section 69 of the South Australian *Evidence Act* (1929) as amended enables a Judge to make an order clearing a court,

where ... [it is considered] ... desirable in the interests of the administration of justice or in order to prevent hardship or embarrassment to any person.<sup>179</sup>

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orders for persons placing others at risk for HIV transmission) 'are to be heard in a closed court'.

<sup>175</sup> s. 38 *Public Health Act* (1991)(N.S.W.).

<sup>176</sup> s. 129(a) *Health Act* (1958).

<sup>177</sup> s. 128 *Health Act* (1958).

<sup>178</sup> Supreme Court of Victoria January 13 1994, No. 10350 of 1993 before Beach J at p. 10.

<sup>179</sup> s. 69 *Evidence Act* (S.A.)(1929).

Although not an HIV/AIDS specific provision, an application could be made for court closure under the provision where a party is HIV-infected.

### (iii) Suppression Orders

In the Northern Territory, New South Wales, Victoria, South Australia, Queensland and the Australian Capital Territory, public health legislation contains general secrecy provisions that would be applicable to HIV-related information.<sup>180</sup> The New South Wales and Victorian legislation is AIDS-specific. The value of such legislation is questionable since the legislation places limitations on the protection where required as a matter of public interest. Where the public interest so demands, the legislation allows such information to be released in open courts.

Suppression orders can be imposed under some State legislation. Such orders can prohibit the publication of specified evidence, or of any account or report of specified evidence, or the name of a party or witness or a person alluded to in the course of proceedings before the court, or of any other material tending to identify any such person.<sup>181</sup> The question whether prejudice and undue hardship would occur if the order were not made should be accorded more weight. However, one provision notes that the public interest in publication of certain information must be recognised as a consideration of substantial weight. Section 71(a) of the *Evidence Act Amendment Act (1989)*(S.A.) places restrictions upon reporting information relating to sexual offences. Neither the identity of the accused nor the victim should be reported until the trial begins.

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<sup>180</sup> s. 29 *Notifiable Diseases Act (1981)*(N.T.); s. 17 *Public Health Act (1991)*(N.S.W.); s. 128, 129(c) *Health Act (1958)*(Vic.); s. 141 *Health Services Act (1988)*(Vic.); s. 49(1) *Health Act Amendment Act (1988)*(Qld.); *Public and Environmental Health Act (1987)*(S.A.); s. 56 *Health Services Act (1990)*(A.C.T.); s. 19 *HIV/AIDS Preventative Measures Act (1993)*(Tas.). Limits on protection are specified in the A.C.T., S.A., and Tas. under these same provisions and in N.S.W. under s. 17 *Public Health Act (1991)*; under s. 48(4) *Health Act Amendment Act (1988)* (Qld.).

<sup>181</sup> s. 68(b)-69(a) *Evidence Act Amendment Act (1989)* (S.A.). Under s. 35 of the *Public Health Act (1991)*(N.S.W.) the court may make a 'no publication' order either of its own volition or upon application by either party to the proceedings. It is an offence to breach a 'no publication' order. Section 129(c) of the *Health Act (1958)*(Vic.) allows the court to make a suppression order during proceedings concerning HIV-infected persons. Section 21(8) of the *Tasmanian HIV/AIDS Preventative Measures Act (1993)* contains a complete restriction on publishing details of an order heard under Division 3 of the Act relating to transmission of HIV. The New South Wales, Victorian and Tasmanian provisions are HIV-specific.

The issue of suppressing confidential information concerning persons suffering from communicable diseases has come before the courts. In two Western Australian cases an injunction has been granted to prevent the release of information by news organisations that may serve to identify persons infected with communicable diseases. In *X v Sattler and Others*<sup>182</sup> Kennedy J relied on the law of defamation to protect the identity of the person with HIV from media publicity. It is important to note, however, that the defendants did not plead either the defence of justification (truth) or qualified privilege (need to know). If the defence of truth had been pleaded there would have been very little an HIV-infected person could have been done to prevent publication of his or her infected status. His Honour in *Sattler* indicated that had the defendants' done so then a clash of competing interests would have been inevitable and precedent would have favoured the refusal of the injunction.

Defamation law currently varies between States particularly with respect to the defences available to the media.<sup>183</sup> This has prompted calls for unification of all Australian defamation legislation. Discussion Papers released on defamation by three States, Queensland, New South Wales and Victoria, have proposed that the defence of truth in defamation would not be available where the material published related to the health, private behaviour, home life or personal or family relationships of a person. There are proposed exceptions where the public interest or personal safety of an individual so demanded.<sup>184</sup>

In contrast to *Sattler*, in the Western Australian case of *Y v TVW Enterprises*<sup>185</sup> Wallwork J relied on the law of confidentiality in granting the injunction preventing the publication of the identity of a Hepatitis B infected health care worker. Wallwork J referred to the judgment of Rose J in the English case of *X v Y and Others*<sup>186</sup> which concerned HIV-infected health

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<sup>182</sup> unreported judgment Supreme Court of WA, 1783 /1989.

<sup>183</sup> For example, the truth alone of an imputation is a defence in Victoria, South Australia, Western Australia and the Northern Territory. However, truth is a defence only if the publication is for the public benefit in Queensland (s. 376 *Criminal Code*), Tasmania (s. 15 *Defamation Act* (1957)), or if in the 'public interest' in New South Wales and the Australian Capital Territory (s. 356 *Defamation Act* (1901)(N.S.W.) which still applies in the ACT).

<sup>184</sup> Privacy move in Eastern States' (1991) 2(4) *National HIV/AIDS Legal Link Newsletter*, 4.

<sup>185</sup> unreported judgment Supreme Court of WA, 1039/1990.

<sup>186</sup> (1988) 2 All ER 648 per Rose J, at p. 660-661.

workers. In *X v Y* the defendant argued that there was a public interest in knowing about persons suffering from HIV infection. The court granted an injunction to prevent publication of the names of two HIV-infected doctors practising in a hospital. Rose J held that the public interest in respecting a person's confidentiality outweighed the freedom of the press to make the identities of the two doctors known. Wallwork J in *TVW* also held that the public interest in the freedom of the press to identify HIV/AIDS sufferers was outweighed by other circumstances of the case. He cited with approval a passage from the judgment of Rose J in *X v Y*:

if the confidentiality of people with HIV/AIDS is breached, "patients will be reluctant to come forward and to continue with treatment and in particular with counselling. If the actual or apprehended breach is to the press, that reluctance is likely to be very great. If treatment is not provided or continued, the individual will be deprived of its benefit and the public are likely to suffer from an increase in the rate of the spread of the disease. The preservation of confidentiality is therefore in the public interest." <sup>187</sup>

Both these cases illustrate first that the media and not only the medical profession have a duty to protect confidences because of the nature of the communications involved. Second, it is clear that the law recognises a public interest in the protection of confidences. Third, there is an exception to confidentiality where disclosure is required in the public interest or for the safety of the public but, fourth, the very width of such an expression upon which minds may differ requires a court to balance carefully the competing public interests which support adherence to the confidence and exceptional permission to breach it. Certainly the public interest in the publication of certain information must be recognised as a consideration of substantial weight.

The decision in *X v Y* is difficult to reconcile with the later decision of the Court of Appeal in *W v Edgell*. <sup>188</sup> Here the court held that a doctor had not breached the confidence of a mental health patient by disclosing contents of a report prepared at the patient's request (which recommended that he receive further treatment) for use in a transfer application (a transfer from a hospital to a regional secure unit) to the hospital authorities. This was

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<sup>187</sup> *supra* note 183, per Wallwork J citing from p. 656 of the judgment of Rose J in *X v Y* (at p. 4).

<sup>188</sup> *supra* note 156.

despite the fact that the solicitors for the patient had withdrawn the transfer application. The Judge believed that the balancing test to be performed here was to strike a balance between first, the public interest in maintaining professional confidences and second, the public interest in protecting the public against possible violence.<sup>189</sup> He believed that the latter outweighed the former.

However, it is difficult to understand why the Judge came to this decision when there was no way the defendant was likely to be released given that the transfer application had been withdrawn. The material contained in this report if it was to be provided at all could have been made available to authorities at a later date should the patient have made another application. Alternatively, if the original material was accurate and still applicable at a later date, no doubt a subsequent doctor would make the same assessment. Rather than permit this breach of confidence the court should have prevented it. By comparing this decision to *X v Y* it can be argued that maintaining the confidentiality of doctors with HIV infection is seen as more worthy of protection in the public interest than maintaining the confidentiality of a mental health patient. This decision arguably places an HIV-infected person who has been charged with a transmission offence and seeks to suppress his or her identity, in a precarious position in England.

In Australia, although courts will protect the identity of HIV-infected plaintiffs in civil cases<sup>190</sup> it has been held that there is no authority to suppress the name of the defendant.<sup>191</sup> In criminal matters pertaining to HIV the court has taken a similar stance following conviction.<sup>192</sup> For example, in

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<sup>189</sup> *Ibid*, at p. 852.

<sup>190</sup> *TK v Australian Red Cross Society* (1985) 1 NSWLR 1; *PQ v Australian Red Cross Society* [1992] 1 VR 875; and *Re a Proposed Proceeding Between TC as Plaintiff and Australian Red Cross Society* unreported judgment of the Victorian Supreme Court, August 4 1989 per Young J, where the plaintiffs were allowed to be referred to by pseudonyms.

<sup>191</sup> In *DM and DT* unreported judgment of the New South Wales Supreme Court February 4 1994, Cole J refused to suppress the defendant's identity (here the defendant was doctor in a case regarding medically acquired AIDS). The parties finally agreed to settle out of court. One may speculate that the refusal of the judge to protect the doctor's identity led to him settle out of court.

<sup>192</sup> During the trial, however, it has held that while there is no common law judicial power to make an order forbidding publication by the media of the names of witnesses and other material which would serve to identify them, courts have a power to order that witnesses at a trial should be addressed and referred to in pseudonyms (per Hunt J in *Savvas, Stevens Peisley* [1989] 40 A. Crim. R. 331, at p. 334 and 336). Again the court would have to weigh the public interest in the freedom of the press against the public interest in due administration of justice and the right of an accused person to a fair trial.

*Herald & Weekly Times Limited v Braun & Ors* <sup>193</sup> a suppression order preventing publication of a male transvestite prostitute (SS) was lifted at the conclusion of the trial upon application by the newspaper. SS had been charged and found guilty of loitering with intent to engage in prostitution. The defendant was infected with HIV and had continued to work as a prostitute and share needles with other intravenous drug users despite the possibility that he could infect others. Two Magistrates initially ordered that the identity of SS be suppressed during the trial on the grounds that if his identity was known it would lead to a deterioration in his condition and hasten his death. It was suppressed under section 129 of the *Health Act* (1958). However, section 119(e) of the Act only allows an HIV-infected person's rights to be protected if those rights do not infringe on the well-being of others. This section requires people infected with HIV to behave responsibly and not pass the virus on to others. The question for the Supreme Court on appeal was whether section 119 was paramount over section 129. The court held that as SS was still likely to practise unsafe sex and share needles, he had forfeited his right to privacy and could not avail himself of the protection of the Act. <sup>194</sup>

Hence it was not his status *per se* but the manner in which he was behaving that was relevant. Courts will be justified in lifting suppression orders if it is done to protect others from the risk of becoming infected. This case can be regarded as a backward step for encouraging persons infected with HIV to come forward and declaring their status in court for the purpose of mitigating sentence. The Magistrate in this case in sentencing SS had imposed the requirement that he abide by the directions of a doctor and not enter a particular suburb of Melbourne. It might have been apt to impose treatment for drug rehabilitation on SS as well. In light of these orders and the fact that public health authorities could have monitored the defendant, it was counterproductive and unnecessary to reveal the identity of this person to the world at large through the media. In the present writers view if the activities of this person were to pose a risk to the community at large then a more incapacitating sentence should have meted out initially or the sentence should have been appealed by the Crown. Allowing a person to be harangued by the media is not a 'sentence' that is known to the law. Finally, the decision allows the media to single out sex workers and prostitutes as a

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<sup>193</sup> Supreme Court of Victoria January 13 1994, No. 10350 of 1993 before Beach J.

<sup>194</sup> *Ibid*, per Beach J at p. 14. Under the *HIV/AIDS Preventative Measures Act* (1993)(Tas.) there is a complete prohibition on publication of any details relating to an s. 21 order imposed on a person placing others at risk of transmission (s. 21(8)).



group that is high-risk for transmission of HIV. It was stated in chapter two of this thesis that this view is not supported by evidence.

### SENTENCING AN HIV-INFECTED PERSON

The sentencing component of a criminal trial is of special significance to an HIV-infected person who may if receiving a sentence of imprisonment spend the remainder of his or life (shortened through progression to AIDS) in prison. Before analysing the sentences that have been meted out to HIV-infected persons for criminal activity it is essential to examine the goals of sentencing. This will assist in deciding whether one can justify the imposition of penalties where HIV-related activity or an HIV-infected person is involved.

#### (i) General Sentencing Theory

Behind the process of sentencing are two main criteria. The first is that the punishment must be linked to the crime, and the second is that the punishment be just and of appropriate severity. Hence, it is generally accepted that detention must not be arbitrary but appropriately applied in the individual case; imposed humanely and not for merely punitive reasons; and, must not defy accepted community standards or just sentencing principles.<sup>195</sup>

There are other stated goals or objectives of sentencing which underlie particular sentences. In chapter two it was noted that some writers believe that the aims of the criminal law are general deterrence, retribution, incapacitation and rehabilitation. It is more likely that they are the goals behind sentencing. There are no statutory rules in relation to the priority which should be accorded to the various purposes or goals of punishment.<sup>196</sup>

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<sup>195</sup> Wilkie, M., 'Crime (Serious and Repeat Offenders) Sentencing Act 1992: A Human Rights Perspective' (1992) 22 *University of Western Australia Law Review*, 187-196.

<sup>196</sup> Under s. 5 of the *Sentencing Act* (1991)(Vic.) sentences may only be imposed:

- '(a) to punish the offender to an extent and in a manner which is just in all the circumstances; or
- (b) to deter the offender or other persons from committing offences of the same or a similar character; or
- (c) to establish conditions within which it is considered by the court that rehabilitation of the offender may be facilitated; or
- (d) to manifest the denunciation by the court of the type of conduct in which the offender engaged; or
- (e) to protect the community from the offender; or
- (f) a combination of two or more of those purposes'.

However, many academics support the view that proportionality has emerged as the guiding principle in sentencing for the 1990s.<sup>197</sup>

It is thought that respect for the system of criminal justice is maintained by consistency in punishment across particular crimes and offenders. In fact, the breadth of sentencing discretion tends to undermine the principles of consistency and certainty, principles which are central to criminal law. The sentencing process is one area where Judges have more overtly acknowledged discretion than in many other respects of their formal functions. As such, Judges have not only a substantial power to manipulate public opinion but also an outlet for imposing their views and possibly their unstated social prejudices about an accused's and the victim's conduct.<sup>198</sup> In sentencing decisions in those States where there are now sentencing statutes there is still room for the exercise of discretion, in particular, the emphasis that a particular Judge may place on the goals of sentencing. The goals require examination in the context of sentencing an HIV-infected person.

### *General Deterrence*

General deterrence relies on the infliction of punishment to inhibit wrongful behaviour. The rationality behind deterrence is that people will generally guide their behaviour by weighing the benefits and costs to be derived from pursuing a course of action.<sup>199</sup> The key to deterrence is to instil so great a fear of punishment in relation to breaking the law that potential criminals will be deterred. However, deterrence ought not be thought of as the overriding rationale of the criminal law, for many crimes cannot be deterred. Some people will still commit crime out of dire need or because they have no fear of sanction. The latter could occur where they are already on a death sentence, for example, if dying from a terminal disease like AIDS.

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The Victorian legislature does not seek to prioritise one purpose over another.

<sup>197</sup> Von Hirsch, A., 'Proportionality in punishment' Tonry, M., and Morris, N., (1992) 16 *Crime and Justice*, 55-98. Ashworth, A., *Principles of Sentencing*, Oxford, Clarendon Press, 1992. A view also held by the judiciary: *R v Knight* (1988) VR 705; and at the High Court level: *Veen v The Queen [No. 2]* (1988) 164 CLR 465 at p. 472 per Mason CJ, Brennan, Dawson, Toohey JJ.

<sup>198</sup> Wilson, B., and Carter, M., 'Rape, Good Women, Bad women and Judges' (1992) 17(1) *Alternative Law Journal* 6-9; Cass, D., 'Hakopian - Case and Comment' (1992) 16 *Criminal Law Journal*, 200-204.

<sup>199</sup> Levine, J. P., Musheno, M. C., Palumbo, D. J., *Criminal Justice : a public policy approach*, New York, Harcourt Brace Jovanovich, 1980, at p. 355.

Levine *et al* , state that for deterrence to work and crime to be reduced, five conditions must be present. First, the threats must be adequately communicated to the group. Many people are unaware of the penalties for crime. Second, there must be a high degree of certainty that the crime attempted to be committed will be punished. The third criterion is that punishment must be sufficiently severe to invoke fear. Fourth, the criminal population must have a rational aversion to legal threats that makes them responsive to deterrence attempts. The final requirement is that the punishment be administered swiftly.<sup>200</sup>

There are practical problems to ensuring the viability of deterrence as a rationale behind sentencing in the criminal process. These include political unfeasibility, difficulties with implementation, economic costs and the possible injustice in inflicting punishments that are too great and that may lead to a loss of respect for the law. In order to be effective, deterrents must often exceed the limits of what is morally acceptable and, since retributive and humanitarian limits are often imposed on penalties, they may not be deterrents. Walker states that the doubt behind deterrents actually deterring was exemplified by the death penalty, which had no real effect on murder rates in a number of jurisdictions studied.<sup>201</sup> The Australian Law Reform Commission in its Report on *Sentencing* has endorsed this doubt by rejecting general deterrence as a goal of sentencing and as a reason for imprisonment as a sanction.<sup>202</sup>

Although it has already been stated that the effectiveness of deterrence in the situation where a person is already on a death sentence from AIDS is questionable, it may be the most important goal of the criminal law in the context of a disease epidemic. Perhaps the threat of the criminal sanction and imprisonment will prevent some people from taking unreasonable risks that may transmit the virus. In most cases, though, conduct that spreads the disease will be spontaneous, driven by passion or anguish and without motive or pre-thought, and hence undeterrable. As has been argued consistently throughout this thesis, the law has to be careful in the AIDS context not to be seen to impose purely symbolic statutory offences

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<sup>200</sup> Levine, *Ibid* at p. 358-373.

<sup>201</sup> Walker, N., *Punishment, Danger and Stigma: The Morality of Criminal Justice* , Oxford, Basil Blackwell, 1980, at p. 66-67.

<sup>202</sup> Australian Law Reform Commission, *Sentencing*, Report No. 44, Canberra, Australian Government Publishing Service, 1988, para. 37, at p. 18.

in the name of deterrence, which cannot be implemented. Such legislation might impede educational efforts to curb the spread of HIV.

### *Retribution*

This theory behind the criminal penalty is based on the premise that the justification for inflicting a penalty is that the offender deserves it because of his or her offence. Walker states that the pure retributivist believes that the severity of the penalty should match the offender's culpability and the limiting retributivist believes it should be only the minimum necessary to achieve other aims such as deterrence.<sup>203</sup>

However, if pure retributivism was followed in the punishment of an HIV-infected person, it may be argued that he or she would in effect be punished twice as the disease is not curable. However, disease has not been regarded as punishment that can be aligned with other forms of punishment that the law currently recognises. The principle of 'double punishment' is generally raised where a sentencing court considers past offences when sentencing current offences. It is true, as will be detailed, that courts are taking into account the fact that HIV-infected persons have a short time to live but this has been generally used to reduce penalties not increase them.<sup>204</sup> It is doubtful that there would be support for retribution unless a person intentionally used HIV as a weapon to kill others (which may be hard to prove in the absence of an admission of guilt from the offender).

### *Incapacitation*

Incapacitation can be defined as the right or duty of society to incarcerate a dangerous individual to prevent him or her from doing harm, at least while he or she is deprived of liberty. It is understandable that many people may support the incapacitation of a person who engages in dangerous behaviour until the danger has passed. However it is a preventative sentence rather than one based on the crime being committed. The Australian Law Reform Commission (ALRC) has argued against the elevation of this goal of sentencing, as it conflicts with the aim that the punishment of the offender

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<sup>203</sup> Walker, *supra* note 201, at p. 25-26.

<sup>204</sup> In Australia, see for example the cases of *R v Bailey* (N.S.W. CCA) 3.6.88, *R v Smith* (1987) 44 SASR 587 and *Linou v Hayes* (1988) 47 SASR 172.

should be linked to the crime.<sup>205</sup> This principle has been accorded judicial recognition in *Chester v R*<sup>206</sup> where the Full Court of the High Court held, that 'the common law does not sanction preventative detention. The fundamental principle of proportionality does not permit the increase of a sentence of imprisonment beyond what is proportional to the crime merely for the purpose of extending the protection of society from the recidivism of the offender.'<sup>207</sup>

To incapacitate an HIV-infected person on the ground that he or she may engage in criminal conduct that will spread the virus may involve a lifelong incapacity given that there is no cure for AIDS. The incapacitation of one person will not remove the disease from the community while cases continue to increase. In addition, removing an HIV-infected person to a place of isolation such as a prison may only serve to set up a new group of potential infectees, the healthy prison population. The presence of homosexuality, rape, assault and drug use in prisons render it probable that the virus will be transmitted in that setting.<sup>208</sup>

### *Rehabilitation*

Often incapacitation and rehabilitation are combined as rationales behind penalties. Violent offenders need both incapacitation and rehabilitation. Rehabilitation is defined as the 'restoration of a criminal to a state of physical, mental, and moral health through treatment and training.'<sup>209</sup> The fact that the only treatment to be offered to an HIV-infected person is counselling and care, given that a cure is absent, renders rehabilitation as a rationale behind the introduction of the criminal law for HIV transmission questionable. There are in fact some limitations on rehabilitation. Persons who commit crime out of dire need may continue to do so for the same reason. Treatment will have no effect on those criminals; only socially and mentally defective persons have the potential for cure.

Imprisonment has been largely discredited as a means for

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<sup>205</sup> ALRC, *supra* note 202, para. 37, at p. 18.

<sup>206</sup> (1988) 165 CLR 611.

<sup>207</sup> *Ibid*, at p. 619.

<sup>208</sup> These studies are discussed in chapter seven, pp. 297 - 300.

<sup>209</sup> Levine, *supra* note 199, at p. 402.

attaining this goal, <sup>210</sup> although rehabilitation itself as a means of reducing crime should be encouraged. However, punishment should not be meted out for reasons of rehabilitation but because the offender has broken the law.

(ii) Summary

These four rationales behind the sentencing process when viewed separately would not appear to justify the introduction of the criminal sanction such as imprisonment to penalise the transmission of HIV. However, by incapacitating the HIV-infected person and providing rehabilitative care, such as counselling and medical treatment for opportunistic infections, and drug rehabilitation where relevant <sup>211</sup>, he or she is prevented from engaging in further dangerous conduct. At the same time, other HIV-infected persons in the community may be deterred from engaging in conduct that would spread the virus, and the rest of the community may be protected against infection.

Despite previous failures the Law Reform Commission has argued that these goals should be aimed at 'where it is possible to achieve them within the context of a just punishment'. <sup>212</sup> Further, the Report recommends that imprisonment be the sanction applied only in the most serious of crimes <sup>213</sup> and that it should be viewed as a sanction of last resort. <sup>214</sup> This has been followed in some non-AIDS related case law to date <sup>215</sup> and been statutorily enacted in some jurisdictions. <sup>216</sup> The present writer believes that the sentencing an HIV-infected person to imprisonment should be viewed in this light. Court should consider alternatives to custody when dealing with HIV-infected accused persons.

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<sup>210</sup> ALRC, *supra* note 202, para. 50, at p. 26.

<sup>211</sup> where offered although the Australian Law Reform Commission says it is not offered often, *Ibid*, para. 50, at p. 26.

<sup>212</sup> *Ibid*, para. 48, at p. 24.

<sup>213</sup> *Ibid*, para. 52, at p. 26.

<sup>214</sup> *Ibid*, para. 55, at p. 28, a view endorsed by The Report of the Royal Commission into NSW Prisons, 1978, (the Nagle Report), Victorian Sentencing Committee Report, *Sentencing*, 1988.

<sup>215</sup> for example, *Duncan v R* (1983) 47 ALR 746.

<sup>216</sup> Followed in s. 11 of *Criminal Law (Sentencing) Act* (1988)(S.A.) but not in New South Wales (*Sentencing Act* (1989)). In fact that legislation shows an increasing use of prison as a punishment.

The Commission's Report recommends generally that alternative-to-custody sanctions such as bonds, conditional discharges and community based corrections be available, especially given the negative aspects of prison such as drug use and sexual assault.<sup>217</sup> A recent history of sentencing theory and, to some extent, practice illustrates that there is a tendency of moving away from imprisonment towards other community based sanctions.

At the legislative level also, and following the spirit of the Report, legislation has been passed focusing on the sentencing of fine defaulters who have, and continue to, make up a sizeable percentage of Australian prisoners. The *Magistrates Court (Amendment) Ordinance* (1989)(A.C.T.) specifies that courts are no longer able to impose custodial sentences for non-payment of parking fines. There is no sound reason for incarcerating such persons and all it really does is provide a pool of persons who may be subjected to or who may initiate homosexual activities in the prison that may result in transmission of HIV.<sup>218</sup>

However, this can be contrasted to the position in Queensland where legislative amendments to the *Drugs Misuse Act* in 1986 have operated to impose mandatory life sentences for possession of a First Schedule drug (includes heroin, cocaine) greater than that specified in the Fourth Schedule (heroin and cocaine over 200g). If a person is unable to show that he or she is a drug dependent person then the sentence is mandatory life.<sup>219</sup> The legislation clearly disregards the terms of the *National HIV/AIDS Strategy* which suggests that persons convicted of minor drug use offences 'should wherever practicable, receive non-custodial sentences including orders for treatment, rehabilitation and counselling.'<sup>220</sup>

Legislation has been passed adopting home detention and periodic detention measures in some States and Territories.<sup>221</sup> Again these are

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<sup>217</sup> *supra* note 202, para. 57, at p. 29.

<sup>218</sup> the potential for this conduct to take place in prisons is discussed in chapter seven, pp. 297-300.

<sup>219</sup> s. 9(b)(ii).

<sup>220</sup> para. 5.7.14. There was a similar move to this kind of legislation in New South Wales in 1989. The *Fine Enforcement Legislation (Amendment) Bill* (1989) would have imposed imprisonment on persons who defaulted on fine payments for prostitution offences eradicating the former community services order penalty was rejected by the Upper House during the final reading and has not been re-introduced by the Government.

<sup>221</sup> Home detention has been available since 1986 in the Northern Territory as an alternative to drunk drivers receiving custodial sentences under s. 19A of the *Criminal Law (Conditional Release of Offenders) Act* (1978)(N.T.), in Queensland generally under s. 86, *Corrective*

measures that were considered prior to the advent of HIV infection but are of special significance in the case of an individual convicted of an offence and suffering from HIV or AIDS. In the latter case at least, home detention would be appropriate but it should not resemble quarantine for an HIV-infected person. Such detention has been used in the United States to keep HIV-infected persons out of jail.<sup>222</sup> The advantages of home detention, are that it is cost-effective and reduces the detrimental psychological effects of prison. One instance of home detention had an unsuccessful result in Western Australia when applied as a condition of bail in 1988.<sup>223</sup> Against this background it remains to be analysed how courts have dealt with HIV-infected persons and HIV-related behaviour in the sentencing process.

### (iii) Case-Law Examples of Sentencing HIV-Infected Persons

A number of factors will be taken into account when a court imposes a sentence. In general courts will advert to aspects of the offence and facts about the offender. They include prior convictions, the health of the accused, the nature of the crime, whether or not A pleaded guilty and the effect of the offence on the victim. Some of these factors have been laid down by statute and others flow through from decisions in reported cases. They are divided into two categories, mitigating and aggravating factors.

Mitigating factors have included provocation, youth or old age, entrapment, personal circumstances such as ill health, hardship to the offender, effect of intoxicants, previous good character, remorse, assisting law enforcement agencies and seeking treatment voluntarily.<sup>224</sup> Circumstances of aggravation have included whether the offence was pre-meditated, the use of a weapon, harm to the victim, and knowledge that the victim is from a vulnerable group (for example, a child, elderly or incapacitated mentally or physically).<sup>225</sup>

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*Services Act (1988) and South Australia from 1987 under s. 37, Correctional Services Act (1982)(S.A.). Periodic Detention is available in New South Wales for sentences of less than three months and offences against the Summary Offences Act (1988)(N.S.W.) as set out in s. 5A Periodic Detention of Prisoners (Amendment) Act (1992).*

<sup>222</sup> George, A., 'Home detention, the privatisation of corrections', *Legal Service Bulletin*, October 1988, 211-213.

<sup>223</sup> See earlier in this chapter, *supra* notes 33-35.

<sup>224</sup> Fox, R., and Freiberg, A., *Sentencing: State and Federal Law in Victoria*, Melbourne, Oxford University Press, 1985, at para. 11.401-11.603.

<sup>225</sup> Fox and Freiberg, *Ibid*, para. 11.301-11.314.



Although the Australian Law Reform Commission report was released in 1988 it makes no specific recommendation in relation to the health of offenders or what factors are to be considered mitigating or aggravating in sentencing an HIV-infected person. Therefore, current judicial officers must rely on existing precedent or follow the legislative provisions. Sentencing HIV-infected persons presents two problems. One issue is whether diminished life expectancy should be a mitigating sentencing factor. The other is the need for courts to consider whether intentional transfer of HIV is an aggravating factor in a prosecution for the underlying offence. All the precedents have concerned a sentence of imprisonment. As such, there have been few non-custodial sentences reported <sup>226</sup> and no judicial pronouncements on whether non-custodial options should be a preferred sentence meted out to an HIV-infected convicted person.

#### *HIV-Infection as a Mitigating Factor*

In general, where a prisoner's HIV-infected health status is regarded as likely to impose a great burden on his or her health then this has operated as a 'mitigating' factor and the original sentence has been reduced (where appealed) or a sentence at the lower end of the general range has been imposed. The first reported precedent in this regard was *R v Smith* <sup>227</sup> which was followed in a number of other cases. <sup>228</sup> In some cases it has reduced a non-parole period from five years to fifteen months <sup>229</sup>, four years to two years <sup>230</sup> and three years to nine months. <sup>231</sup> *Smith* did not involve a transmission related offence. The court noted that health as a factor in

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<sup>226</sup> There is one unreported judgment from South Australia dated 27 November 1992 where a defendant convicted of possession of heroin received a suspended sentence from Millhouse J on grounds which included the fact that her husband was dying of AIDS, that the accused had no prior convictions, that she was the breadwinner and had sole responsibility to care for her children. It is unclear whether the AIDS status of the husband was a major factor in awarding the suspension of the sentence or just one of a number of considerations:

<sup>227</sup> *supra* note 204.

<sup>228</sup> *Linou v Hayes supra* note 204, *R v McDonald* (1988) 38 A. Crim. R. 470, *R v Harris* unreported judgment of the South Australian Supreme Court October 27 1990.

<sup>229</sup> *Harris, Ibid.*

<sup>230</sup> *Linou v Hayes supra* note 204.

<sup>231</sup> *Smith, supra* note 204.

reducing sentence must be treated with caution. King CJ expressed the view of the court:

Ill health cannot be allowed to become a licence to commit crime, nor can offenders generally expect to escape punishment because of the condition of their health. It is the responsibility of the Correctional Services authorities to provide appropriate care and treatment for sick prisoners. Generally speaking ill health will be a factor tending to mitigate punishment only when it appears that imprisonment will be a greater burden on the offender by reason of his state of health or when there is a serious risk of imprisonment having a gravely adverse effect on the offender's health.<sup>232</sup>

From this judgment it is apparent that information put in evidence by A's counsel pertaining to categories of infection and the rate of progression through the various stages of HIV infection was instrumental to the decision.

In *Bailey v DPP*<sup>233</sup>, Lee J held that in consideration of all the facts there was no ground for a reduction in sentence of the non-parole period. The fact that Long Bay Jail had the Malabar Assessment Unit at the time, which specifically housed HIV-infected prisoners, may have been important to the judgment as His Honour believed that prison authorities had attempted to make HIV-infected prisoners as comfortable as possible. This point was later disputed and recognised as a ground for reduction of the sentence and non-parole period in *R v McDonald*.<sup>234</sup> A similar view to that expressed in *Bailey* as to the weight to be attached to HIV-infection was stated in *R v Donald*<sup>235</sup> where the court held that the fact the appellant was HIV-infected was not evidence that imprisonment would bear more heavily upon him 'until and unless AIDS disease progresses'

In 1993 in *R v Dowlett*,<sup>236</sup> the New South Wales Court of Criminal Appeal confirmed that it is the T-cell ('CD4') level counts that is important in an individual and not whether he or she could be categorised as either HIVi

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<sup>232</sup> *supra* note 204, at p. 598 per King CJ. The Victorian Court of Criminal Appeal in *Eliassen v R* (1990) 53 A. Crim. R. 391 at 396 affirmed this principle.

<sup>233</sup> (1988) 78 ALR 116 (HC) and later returned to the NSW SC (1988) 35 A. Crim. R. 458 at p. 463 per Lee J.

<sup>234</sup> *supra* note 228, per Roden J, at p. 470.

<sup>235</sup> unreported judgment South Australian Court of Criminal Appeal, July 17 1989.

<sup>236</sup> unreported judgment of the New South Wales Court of Criminal Appeal, July 6 1993.

infected or suffering from AIDS. Although they could have done and should have, the court in *Dowlett* did not confirm that it is erroneous to consider that a person is not suffering hardship because he or she is yet to develop an AIDS defining condition.

By contrast, the risk of A contracting HIV in prison, given that she was an IV drug user, was considered a relevant factor in rejecting an appeal from the DPP against leniency of sentence in *Bayliss*.<sup>237</sup> However, the respondent only had three weeks left to serve and was undergoing a successful rehabilitation programme. In an instructive judgment, Roden J held:

If there is firm evidence that imprisonment of heroin addicts significantly increases the risk that they will contract AIDS (with the consequent potential of great spread of the disease through the general community) then the courts and the community must look to the need to design criminal sanctions, and to manage places of detention, in such a manner as to minimise the risk and to avoid placing persons who are in a high risk category in an even more dangerous environment. ... if the problem is not addressed and remedied, sentencing courts will be confronted by a dilemma, which I venture to suggest many judges and magistrates will find presents a crisis of conscience, with possible conflict between their duty and their humanity.<sup>238</sup>

In 1993, in the case of *R v Jones*<sup>239</sup> the New South Wales court firmly asserted that where the offences that are committed by the defendant are very serious in nature (here they were multiple sexual assaults committed while on parole for similar offences) then a prisoner will be disentitled to the 'health factor' discount. Further, the court took the view that it is for the Executive to grant early release not the judiciary. Such a view is firmly endorsed by statute in that State.<sup>240</sup> A similar view was also stated in a 1992

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<sup>237</sup> unreported judgment of the New South Wales Court of Criminal Appeal, November 3 1988.

<sup>238</sup> *Ibid*, per Roden J at p. 5.

<sup>239</sup> unreported judgment of New South Wales Court of Criminal Appeal, 15 December 1993, reported in Anon, 'HIV Sentencing Goes Off the Rails' (1994) 5(1) *National HIV/AIDS Legal Link Newsletter*, 10.

<sup>240</sup> Royal Prerogative of mercy and s. 25A *Sentencing Act* (1989)(NSW)

English case.<sup>241</sup> These cases reveal that the judiciary are placing checks on their sentencing discretion and in the instance of HIV/AIDS could be said to be engaged in a 'passing the buck' exercise. This is arguably evidenced by the failure of the High Court to deal at all with the reasons why they denied special leave to appeal to Jones in his 1994 application apart from stating 'in the very special circumstances of this case, special leave is refused'.<sup>242</sup> It is argued by Buchanan that the court was reluctant to entertain the application because the nature of the offences were such that little could be done to adjust the sentence in proportion to his remaining life.<sup>243</sup> Further, it is thought that this case more than any other encountered under the spectre of HIV/AIDS thus far, raised thorny questions about 'preventative custody' an area that the High Court would have been reluctant to re-visit, especially in the AIDS context.<sup>244</sup> Hence later courts may not be disposed to hold that antibody status will necessarily result in a burden to A in the prison setting, a burden which guarantees early release. In the final analysis, these cases accord with the view of Perry J in *Linou v Hayes* where he stated that a hard and fast rule should not be laid down with respect to the effect of HIV-infection on sentencing and that each case should be considered on its own merits.<sup>245</sup>

#### *HIV-Infection as an Aggravating Factor*

In *R v Wright*<sup>246</sup> HIV was regarded as an aggravating factor. A had committed a number of sexual offences on young males whom he had

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<sup>241</sup> *R v Stark* [1992] Crim LR 384 on appeal to the House of Lords. In this case the accused had developed AIDS and his life expectancy was estimated at between 12 months and 2 years. The court believed that it was not its province to manipulate a perfectly appropriate sentence because the conditions in prisons made life particularly hard for the appellant. The House of Lords decision can be compared to that in *Moore* (1990) 12 Cr App R 384 where the court took a different view. It is also significant that in *Stark*, the indictment had been allowed to lie in court because of the accused's condition. When he was subsequently arrested for possession of heroin again, the prior charge was activated. Although it is not clear from the judgment, one could speculate that the court believed that the accused had already been in receipt of lenient treatment prior to the trial.

<sup>242</sup> per Mason CJ, Deane and Toohey JJ.

<sup>243</sup> Buchanan, D., 'High Court rejects sentencing appeal' (1994) 5(2) *HIV/AIDS Legal Link Newsletter*, 12-13.

<sup>244</sup> *Ibid*, at p. 13. This matter was considered by the High Court in the non-AIDS related case of *R v Chester* *supra* note 206.

<sup>245</sup> *supra* note 204, per Perry J, at p. 176.

<sup>246</sup> unreported Tas SC September 27 1990.

befriended. In passing sentence Cox J took into consideration the fact that A knew he had HIV at the time the offences were committed. His irresponsibility in not protecting his victims from infection was viewed by the Judge as an important factor.<sup>247</sup>

The decision has been criticised.<sup>248</sup> The first ground is that the decision contradicts the principle handed down in the High Court case of *R v Simoni*.<sup>249</sup> In *Simoni*, the High Court held that a person may only be sentenced for the offence for which he or she was convicted. Hence aggravating features should be part of the charge and cannot be taken into account in sentencing if such factors would have warranted a more serious offence in the first place. Hence A should have been charged with aggravated sexual assault, the HIV infection being the circumstance of aggravation. A could have appealed against his sentence on this ground.

The second criticism is that the judgment illustrates the ignorance that can be held by judges in relation to HIV infection. In passing sentence Cox J noted that oral sex was a 'risky' practice. However, there is no reported case where HIV has been transmitted by saliva or semen swallowed through oral sex. Perhaps defence counsel did not place all the necessary medical evidence before the court. In other cases such evidence has been available. His Honour also made reference to haemophilia as an innocent mode of acquiring HIV. Use of such terms as 'innocent' and 'guilty' with respect to the modes of transmission of HIV have no place in the sentencing process. The Australian Law Reform Commission in its report on Sentencing advocated that Judges receive ongoing legal training on sentencing practice.<sup>250</sup> Following *Wright*, one can add to that the requirement that some formal AIDS education is also necessary.

The final criticism is that the judge stated that the possibility of deterioration in A's physical condition was not an appropriate consideration for the court. His Honour held that A's deteriorating condition did not override the fact he acted both with knowledge of his status and that his activities could

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<sup>247</sup> known or assumed HIV status was regarded as an aggravating feature in England in *R v Malcolm* [1988] Crim. LR 189 and in the US in *Cooper v State of Florida*, 539 So 2d 508 (Fl D CA, 1989).

<sup>248</sup> Patterson, D., 'PLWA's and the criminal justice system' (1990) *National AIDS Bulletin*, 34.

<sup>249</sup> (1981) 35 ALR 265, per Gibbs CJ, at pp. 268-269.

<sup>250</sup> *supra* note 202, paras. 278-279, at pp. 152-153.

transmit the virus. <sup>251</sup> Such a comment plainly disregarded the fact that there were precedents to the contrary at the Supreme Court level in a number of States <sup>252</sup> at the time the sentence was being considered.

Of similar concern is the case of *R v Barry*. <sup>253</sup> In this case A, an aboriginal youth, had been convicted of an assault on a police officer. The offending conduct was rubbing excrement into the police officer's face. Wylie J in sentencing A referred to a trend of actual or threatened infliction of AIDS in the commission of criminal offences and felt it was his duty to mark the community's disapproval and provide a deterrent, which outweighed the personal circumstances of the defendant.

This decision can be criticised on a number of grounds. The first ground upon which the decision can be criticised is that the question of prevalence should not have been considered. Although the Australian Law Reform Commission in its report on *Sentencing* was divided on the point, the majority view was that the prevalence or increasing prevalence of a particular offence should be irrelevant to sentencing. <sup>254</sup> The Commission recommended that the penalty for an offence be amended to recognise the increasing prevalence rather than impose societal concerns on a particular offender through his or her sentence. The decision in *Barry* is also reprehensible because there was no evidence submitted of the 'trend'. Third, the length of sentence (three years) meant that Barry was likely to die before it was completed as he was in the later stages of virus. Fourth, undue emphasis was placed on the risk to police officers. There was no evidence that they were at risk at all and there is no reported case of HIV being transmitted through excrement. The decision in *Barry* illustrates a total lack of consideration of all these facts, even on appeal, where the court also ignored the established precedent in cases such as *R v Smith* and *Bailey v DPP*. In addition, the case ignores the spirit of the *Interim Report of the Royal Commission into Aboriginal Deaths in Custody*. <sup>255</sup> Muirhead J recommended that Australian governments should legislate to enforce the

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<sup>251</sup> This occurred also in *R v Howard* NSW CCA 328/87 where ameliorating factors (HIV) outweighed any grave aggravating factors in a charge of common assault.

<sup>252</sup> such as the cases of *R v Smith*, *Linou v Hayes* *supra* note 204.

<sup>253</sup> unreported judgment 221/1990 September 17 1990 Qld CCA.

<sup>254</sup> *supra* note 202, para. 177, at p. 95.

<sup>255</sup> Canberra, Australian Government Publishing Service, 1988, at p. 18.

principle that imprisonment is treated as a penalty of last resort for Aboriginals. In January 1991 Barry committed suicide.

*Wright* and *Barry* can only reinforce the view that decisions based on stereotypes and suspicions, unsubstantiated fears are not legally adequate. Both these decisions are misguided, given that generally Australian judges have taken an enlightened and educated approach to sentencing HIV-infected persons. The Victorian *Sentencing Act* (1991) in Part 2 entitled 'Sentencing Guidance' provides that Full Court judges may lay down guideline judgements which would bind judges and magistrates imposing sentence. Such judgements could effectively be used to dispel errors such as those which occurred in both *Wright* and *Barry*. Consistency in the sentencing practice of HIV-infected persons could be achieved. This of course would not remedy the inconsistencies between States and Territories.

There is no reported case where a non-custodial sanction has been imposed taking into account A's HIV-infected status.<sup>256</sup> Such a sanction could have been imposed in the case of *Linou v Hayes* where the prisoner was an IV drug user and as such had the potential to infect the healthy prison population through infected needles. For example, a condition of probation for a person who engages in high-risk behaviour such as IV drug use should include that he or she should undergo AIDS preventative education.

The behaviour of the victim has been shown to be a relevant consideration in sentencing. This issue warrants some consideration since activities which transmit HIV are likely to be engaged in with consent. In a 1991 Victorian County Court decision *R v Hakopian*<sup>257</sup> a sentence for rape was reduced on the basis of the fact that the complainant was a prostitute and as such would feel less violated by rape than a person who was not. Although the case is non-AIDS specific, it could have relevance where a

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<sup>256</sup> Although there are reports that this has been the case in the United States where a man was sentenced to sexual abstinence for five years and house arrest for six months for knowingly spreading HIV through sexual activities ('"No sex" sentence for AIDS carrier', *West Australian*, October 31 1991). Reportedly, the court felt it ludicrous to put the convicted man in prison when he was suffering a fatal illness.

<sup>257</sup> County Court of Victoria, August 1991 per Jones J at pp. 7, 12. The decision was appealed to the Supreme Court of Victoria: in *R v Hakopian* Victorian Court of Criminal Appeal, 11th December 1991. Both the lower court and appellate court decisions were criticised: 'Prostitutes take to the streets over rape', *Weekend Australian*, January 11-12 1992. The issues are covered in some detail by Carter, M., and Wilson, B., 'Rape: good and bad women and judges' (1992) 17(1) *Alternative Law Journal*, 6-9; Cass, D., 'Hakopian - Case and Comment' (1992) 16 *Criminal Law Journal*, 200-204. See also text and footnote 198 *infra*.

homosexual or IV drug user was the complainant in an HIV transmission offence.

The trial judge in *Hakopian* purportedly relied on the earlier case of *AG v Harris* <sup>258</sup> where the Victorian Court of Criminal Appeal held that the fact that a victim of sexual assault was a prostitute is a relevant consideration in sentencing. In *Hakopian*, Jones J suggested that the occupational status of the complainant 'lessens the gravity of the offences'. <sup>259</sup> On appeal the precise question of the accuracy of *Harris* was not debated and the *Hakopian* appeal court implicitly seems to have accepted the case as good law although the decision is not explicitly affirmed. <sup>260</sup> In contrast to both *Hakopian* and *Harris*, in the 1982 New South Wales case of *Marteene* <sup>261</sup> Street CJ had warned against this stance. He stated:

... The complainant undoubtedly did place herself at risk. But this should not deny her the ordinary protection of the criminal law ... There is not the slightest reason for the criminal law to withhold from prostitutes a full measure of protection of their right to determine when and in what circumstances they will permit access to their bodies by men. <sup>262</sup>

*Marteene* would require that sentencing courts not reduce sentences where the complainant comes from a high-risk group on the basis that their behaviour placed them at some known risk. Although the Court of Criminal Appeal in *Hakopian* increased the sentence of the accused agreeing that it was inadequate, the appeal ground that related to the trial judge's assessment of the psychological impact on the victim in the case, given her status as a prostitute, was dropped. Hence the principle that prostitutes (and by extension possibly homosexual males or females) form a less vulnerable class of victims was not overturned by the appeal court.

Therefore, a homosexual, prostitute or IV drug user who is the victim of an HIV transmission offence may be regarded as a less vulnerable victim because he or she might be said to consent to the risk of acquiring HIV

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<sup>258</sup> unreported judgment of the Victorian Court of Criminal Appeal, 11 August 1981, at p. 6.

<sup>259</sup> *supra* note 257, at p. 8.

<sup>260</sup> For example, Crockett J states 'regardless of whether the victim was a prostitute or not, the question is as to whether the offences which were committed upon her were of such a nature as to have caused fear and terror' (*supra* note 257, at p. 12).

<sup>261</sup> Unreported judgment of the New South Wales Court of Criminal Appeal, 8th July 1982.

<sup>262</sup> *Ibid*, at p. 11.



by placing himself or herself in a situation where transmission may occur. As such, transmission of HIV in such circumstances may be seen as a self-inflicted harm. Thus, if the court in *Hakopian* were faced with a fact pattern where instead of the crime being rape and the victim being a female prostitute, the crime was a transmission offence and the victim was either a homosexual or an IV drug user, that same court would all factors being equal have to reduce the sentence that might have been normally awarded to the offender.

#### 4. POST-TRIAL PROCEDURES AND THE VICTIM

In this section the procedure that has special reference to the victims of criminal conduct warrants consideration. This covers the potential for victims of criminal activity to obtain monetary compensation awards for injuries received in HIV-related offences.

##### CRIMINAL INJURIES COMPENSATION AWARDS

In Victoria, in 1991 20 police received compensation under Criminal Injuries Compensation legislation for pain and suffering associated with the possible HIV infection following injury through work-related incidents. The injuries were inflicted during stabbing and biting incidents when dealing with suspects. None of the officers tested positive to the virus.<sup>263</sup> The payments were to be expected given that restrictive interpretations of the Criminal Injuries Compensation Act have been frowned upon at the High Court level.<sup>264</sup> The High Court has held such legislation is a remedial enactment and should not be interpreted restrictively. The same opinion may be applied to other legislation in force in other Australian jurisdictions.<sup>265</sup>

There is little uniformity in the monetary ceilings of the Criminal Injuries Compensation Tribunals.<sup>266</sup> Under all legislation injury must result

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<sup>263</sup> 'Police Defend pay for AIDS trauma', *Sunday Age*, September 15 1991, p. 1.

<sup>264</sup> *Fagan v Crimes Compensation Tribunal* (1982) 150 CLR 666.

<sup>265</sup> *Criminal Injuries Compensation Act* (1983)(Vic.); *Criminal Injuries Compensation Act* (1976)(Tas.); *Crimes Compensation Act* (1982)(N.T.); *Criminal Injuries Compensation Act* (1983)(A.C.T.); *Criminal Injuries Compensation Act* (1985)(W.A.); *Victims Compensation Act* (1987)(N.S.W.); *Criminal Injuries Compensation Act* (1978)(S.A.) as amended in 1988; Part LXVA *Criminal Code* (1899)(Qld.).

from activity that can be classified as criminal. Under all the legislation the term 'injury' includes mental illness, although the definitions are not uniform.<sup>267</sup> In South Australia, emotional distress and fear following rape has been held an injury for the purposes of the legislation.<sup>268</sup> In section 2 of the Australian Capital Territory legislation injury includes the contraction of a disease. In Victoria, given the definition of the term 'victim' in section 3, compensation will be awarded to a person who tries to arrest someone committing a criminal act, prevent it occurring or aid or rescue a victim of a criminal act. Hence the Victorian legislation would cover the transmission of HIV through a wide-range of behaviour.

Presently guidelines have not been set in place on the medical proof required for victim's compensation with respect to AIDS-related matters. Police antecedent reports, criminal records and statements that have been made by witnesses are all tendered as evidence in Victorian Compensation Tribunal hearings. There is the potential for information identifying the victim or the accused as an infected person to be put before the court without any safeguards imposed as to the use of that information.<sup>269</sup>

One of the main impediments for a successful award for the victim is the victim's behaviour. It is provided in the legislation that an award may be reduced having regard to the behaviour of an applicant which contributed to the injury.<sup>270</sup> The Victims Compensation Tribunal in New South Wales in 1989 reduced a compensation award to take into account of the fact that the victim was a gay man and, as such, must impliedly consent at least to the possibility of a degree of violence in his sexual activities.<sup>271</sup> A similar view has been taken by an Ontario, Canada, Criminal Injuries Compensation Board in 1993.<sup>272</sup> In this case, the Board declined to award the maximum

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<sup>266</sup> Tas., N.T., A.C.T., \$25,000. W.A., Vic., N.S.W., S.A., \$50,000) However the maximum for pain and suffering (including mental or nervous shock) under most of the legislation is \$20,000 (Vic., Qld.).

<sup>267</sup> s. 4 (N.T.); s. 4 (S.A.); s. 3, (Vic.); s. 2 (A.C.T.) or mental and nervous shock: s. 1 (W.A.); s. 4 (S. A.); s.663A (Qld.); or injury to mental health: s. 2 (Tas.); s. 3 (N.S.W).

<sup>268</sup> *Sanders v Rowden* (1980) SASR 547.

<sup>269</sup> Bailey, J., 'Criminal Injuries Compensation' (1991) *Law Institute Journal*, 266-268.

<sup>270</sup> s. 20(1) (Vic.); s. 5(1) (Tas.); s. 9(a) (S.A.); s. 25 (W.A.); s. 663B(2) (Qld.); s. 10 (N.T.); s. 15 (A.C.T.); s. 20 (N.S.W).

<sup>271</sup> Godwin, *supra* note 37, at p. 13.

<sup>272</sup> This was the application made after the *Ssenyonga* trial was not completed (discussed chapter three, footnote 140). The Board's finding is cited in Holland, W., 'AIDS and the Criminal Law' (1994) 36 *Criminal Law Quarterly*, 279-316, at p. 288, fn 24.

amount to three complainants who had sexual intercourse with the deceased without knowledge of his HIV-infected status. The Board declined on the basis that it was not 'reasonable to entrust one's life to an almost complete stranger ... a reasonable person would require a much longer period of trust-building'.<sup>273</sup>

Legislation that permits awards to be varied should further deterioration in medical prognosis occur is most important with respect to HIV-related injury.<sup>274</sup> Many compensation schemes require the initial application to be lodged within twelve months,<sup>275</sup> two years,<sup>276</sup> or three years<sup>277</sup> from the date of injury. In Tasmania and Queensland in the absence of any statutory deadline such an application can be brought at any time. Most jurisdictions require the victim to report the crime within a reasonable time. However, by that stage the victim of a transmission offence who subsequently becomes antibody positive may not have begun to suffer the debilitating consequences that the various stages of HIV-infection bring. Recognising this in one State in 1991, procedures were amended to allow for fast track or expedited victim compensation hearings where a person was seriously ill.<sup>278</sup>

## 5. CONCLUSION

This chapter has revealed that there are few guidelines in the criminal process for determining whether an infected accused will have any special rights as a result of his or her infected status. Provisions that relate to bail would have general application to such persons. Similarly, the health discount factor that has always been relevant in sentencing theory would offer guidance to judges. A body of sentencing precedent with respect to HIV-infected persons has already developed. While such sentencing has generally reflected an enlightened approach there are instances which reveal

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<sup>273</sup> Anon, 'Compensation for unsafe sex' (1994) 5(1) National HIV/AIDS Legal Link Newsletter, 3.

<sup>274</sup> s. 5(6) (Tas.).

<sup>275</sup> Victoria, Northern Territory and Australian Capital Territory.

<sup>276</sup> s. 17(2)(d) (N.S.W.).

<sup>277</sup> Western Australia, South Australia.

<sup>278</sup> Bailey, *supra* note 269, at p. 268.

that the judiciary are not cognisant of current scientific information relating to the progression of HIV infection. As sentencing is a discretionary function Judges need to be aware of the standards and views that they are communicating to society through their sentencing decisions.

Many courtroom procedures and applications will involve HIV-infected persons in the future, either as the accused or the victim. The New York Office of Court Administration guidelines are most instructive and sum up the approach that should be taken by Australian courts where an HIV-infected person appears in court.

The handling of a case involving a person afflicted with an infectious disease, particularly a case involving an AIDS infected person, calls for a proper balance between concern for the safety of court personnel who have contact with an afflicted person and the basic right of all people to appear in a courtroom atmosphere of fairness and tranquillity that assures due process, as well as freedom from bias and notoriety.<sup>279</sup>

Many applications will relate to the treatment by the police of suspects being detained in custody. They will involve applications for orders to be made relating to the accused or applications made by the accused through his or her counsel to have certain evidence rendered inadmissible. There is no doubt that the emergence of HIV has resulted in the need to consider the broad based powers of police. As public health officials can delegate their powers of apprehension and detention to the police to act on their behalf the scope for police to come into contact HIV-infected persons is extended. This chapter has revealed that the major area requiring policy direction and development by the legislature pertains to HIV testing. There is an uncertainty about whether a general power to take blood samples should include the power to subject samples to HIV testing. Neither public health legislation nor criminal process legislation addresses this point adequately.

When focus is placed on the victim it can also be seen that apart from criminal injuries compensation legislation which can be adapted to cover HIV-related injuries, the special concerns of the victim with respect to HIV testing are largely ignored by current legislation and practice. In particular, legislatures need to consider whether testing of the accused should be permitted for the purpose of reassuring the victim.

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<sup>279</sup> State of New York Office of Court Administration, *Guidelines for the Handling of A Court Appearance Involving a Person Afflicted with an Infectious Disease*, issued 1/88.

The police and judicial arms of the criminal justice system must aim to set in place clear guidelines which reflect a balance between civil liberties and the due administration of justice. There is a need for Australian States and Territories to establish some degree of certainty and uniformity when processing HIV-infected accused persons through the police and court phases of the criminal justice system.

## CHAPTER 7

### AIDS AND PRISONS

#### 1. INTRODUCTION

A moderate number of Australian prisoners are believed to be infected with HIV. A study conducted at Yatala prison in 1989 revealed that an average of 33% of prisoners were at some risk for the transmission of HIV because they engaged in high-risk activities such as anal intercourse or drug use.<sup>1</sup> Other studies have found that a significant number of prisoners were incarcerated for offences relating to drug use<sup>2</sup> and/or were regular drug users prior to arrest.<sup>3</sup> These details have led commentators to question whether prisons might be 'incubators' for transmission of HIV and a bridge in the transmission of HIV from the prison to the outside community.<sup>4</sup>

This chapter examines the adequacy of prison policies in coping with the AIDS epidemic. Analysis will be made of the incidence of activities

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<sup>1</sup> Douglas, R. M., Gaughwin, M. D., Davies, L. M., *et al*, 'Risk of transmission of the human immunodeficiency virus in the prison setting', *Med J Aust*, 1989, 150:722; and Douglas, R. M., Gaughwin, M. D., Davies, L. M., *et al*, 'Preventing Human Immunodeficiency virus infection among prisoners: Prisoners' and Prison Officers' knowledge of HIV and their Attitudes to Options for Prevention' (1990) XIV (1) *Community Health Studies*, 61-64.

<sup>2</sup> Johnson-Fitzpatrick, G., *et al*, *An Evaluation of Programme Review Committees*, Unpublished report. N.S.W. Department of Corrective Services, Research and Statistics Division, 1988, found 32% of a sample of 104 prisoners reported that their offences were related to drug use.

<sup>3</sup> Dobinson, I., and Ward, P., *Drugs and Crime*, NSW Bureau of Crime Statistics and Research, Research Study 2, Sydney, 1986. 40% of a sample of 225 prisoners convicted of property offences were classified as regular users prior to arrest. A study by Gorta, A., *Estimates of Prior Drug Use by Prisoners in N.S.W. Gaols*, unpublished report, N.S.W. Department of Corrective Services, Research and Statistics Division, June, 1988, focuses on women prisoners and found 65% of a sample of 90 women prisoners reported using heroin prior to arrest. An analysis of 1993 literature reveals that one-third of persons sent to prison in Australia are property offenders (*Australian Prisoners*, Canberra, Institute of Criminology, 1993). There is no breakdown in the figures which would allow a conclusion to be drawn as the number of these offenders who are also drug users.

<sup>4</sup> Strang, H., 'AIDS in Prisons' (1990) 4/6 *National AIDS Bulletin*, p. 42, Egger, S., and Heilpern, H., 'HIV Infection in Australian Prisons', Canberra, Australian Institute of Criminology, 1990, p. 1 and Dwyer, J., 'Minimising the Spread of the Human immunodeficiency Virus Within the Australian Prison System', Conference on HIV/AIDS and Prisons, 19-21 November 1990, Melbourne, reported in Norberry, J., Gaughwin, M., and Gerull, S-A., No. 4 *HIV in Prisons*, Canberra, Australian Institute of Criminology, 1991, 109-114 at p. 109.

that are high-risk for transmission of the virus within prisons, such as consensual and non-consensual sexual activity and drug use. The present policies relating to compulsory testing, segregation, confidentiality, medical treatment and education, which have been developed to prevent the transmission of HIV within the prison, will be critically examined. The examination will involve an analysis of Australia's commitment to the recommendations set down by the World Health Organisation after the 1987 consultation on the Prevention and Control of AIDS in Prisons.<sup>5</sup> Such an analysis will consider how the policies developed to curb the spread of HIV in prisons impact on HIV-infected prisoners and their custodians. Finally, the chapter will consider the efficacy of other methods supported by law which might be implemented to control the spread of HIV in prisons.

## 2. THE PREVALENCE OF HIV IN AUSTRALIAN PRISONS

Apart from a few reported cases on sentencing of HIV-infected persons, it is generally difficult to identify how many AIDS or HIV-infected persons are passing through the criminal justice system. Prisons are the only institution where statistics have been recorded.

In 1989 it was estimated that 99 persons were infected with HIV within Australian prisons. In that same year Heilpern and Egger, argued that the figure was unreliable and observed that 'information on the presence of AIDS and HIV seropositivity ... is not systematically reported in any one source [across the jurisdictions]'.<sup>6</sup> Heilpern and Egger further observed that comparison of data across Australia was problematic because of the differing policies in place from which case data could be obtained. For example, not all prisons had testing policies and even in those that did, uniformity of procedure was not achieved. There is no doubt that the figure of 99 would have been unreliable because HIV testing was not compulsory in all prisons

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<sup>5</sup> WHO, 'Statement from the Consultation on Prevention and Control of AIDS in Prisons', 16-18 November 1987 at the World Health Organisation Special Program on AIDS, Geneva. Australia was a participant and part of a 'consensus statement' that was issued at the end of this special programme. An outline of the 'consensus statement' is presented in Carr, A., 'HIV in Prisons: Forewarned but not Forearmed' (1988) *National AIDS Bulletin*, 8-14, Appendix, at p. 13-14.

<sup>6</sup> Heilpern, H., and Egger, S., *AIDS in Australian Prisons: Issues and Policy Options*, Canberra, Department of Community Health and Services, 1989, at p. 26.

at that time and more importantly testing was not compulsory in NSW<sup>7</sup> which is the State with the largest prison population in Australia.<sup>8</sup>

In 1990, the same researchers stated that the process of information gathering seemed to have 'deteriorated' further.<sup>9</sup> As of November 1990, the number of HIV positive prisoners in Australian prisons was reported to be 39 out of a total prison population of 13,319<sup>10</sup> with one case of AIDS. In addition, a low rate of seroprevalence (the proportion of HIV positive prisoners as a function of the number of prisoners tested) was found to be 0 to 0.4%.<sup>11</sup>

The most recently recorded official figure for the number of HIV-infected persons in Australian prisons, reported as at October 1991, was 206.<sup>12</sup> The statistics seem misleading because not all jurisdictions provide information on the number of persons tested each year. The fact that by 1990 there were 39 and not 99 (as in 1989) prisoners infected with HIV illustrates the rapid turnover of prisoners. This is a characteristic of prison populations and a factor which should serve to heighten the need to adopt uniform policies 'inside' to prevent the spread of HIV on the 'outside' following the release of prisoners.

An analysis of the official figure represented above would suggest that HIV is not a significant problem in prisons. However, it is implied from the research that the figures are a conservative estimate. Similar problems with ascertaining prevalence have been encountered in other countries with many researchers in agreement that official figures need to be treated with scepticism.<sup>13</sup> In fact, a study of the figures from the United States and

<sup>7</sup> it having only become compulsory in November 1990 following passage of the *Prisons (Medical Tests) Amendment Act (N.S.W.)(1990)*.

<sup>8</sup> Australian Institute of Criminology, *Prison Trends*, No. 208, June 1993. This document reports that the NSW prison population as of June 1993 is 6,373 and the Victorian population is 2,401.

<sup>9</sup> Egger, S., and Heilpern, H., 'HIV Infection in Australian Prisons' Paper presented at Conference on HIV/AIDS and Prisons, 19-21 November 1990, Melbourne, *supra* note 4, 65-84 at p. 66.

<sup>10</sup> (June 1990 statistics). Table 2, p. 21.

<sup>11</sup> Egger and Heilpern, *supra* note 4, at p. 67.

<sup>12</sup> Norberry, J., 'HIV/AIDS, Prisons and the Law' (1991) 32 *Trends and Issues*, at p. 1. A further study has been completed by Norberry but will not be released until end of 1994 (Personal Correspondence with Jennifer Norberry, Parliamentary Library, Canberra).

<sup>13</sup> In England and Wales in 1989 it was confirmed that 63 current prisoners were HIV positive and 174 had been released. Only three men had developed AIDS since 1985 (cited in Thomas, P., 'HIV/AIDS in Prisons' (1990) 1 *The Howard Journal*, 1-13, at p. 2-3).



Europe is instructive as they may indicate the future course of the epidemic in Australian prisons. For example, the prevalence of HIV infection in prisons in the United States and Europe ranges from less than 1% to greater than 25% among all prisoners, and up to 60% in those prisons where IV drug users are imprisoned.<sup>14</sup> In the United States in 1986, the incidence rate of AIDS was higher in the prison population than in the general population: 5.3 cases per 100,000 in the general population as compared to 5-215 cases per 100,000 in State and Federal correctional institutions.<sup>15</sup> Given the incidence of HIV infection in US prisons, Australian prisons could be on the brink of an increase in HIV cases.

The official Australian figures presented should be given serious consideration since it is well-documented that both consensual and non-consensual activities capable of transmitting HIV take place in prisons. The fact that the figures may really be much higher means that a more adequate method of obtaining statistical information must be developed. It is only on the basis of reliable information that stringent policies can be sustained.

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However, the Director of the Prison Medical Service estimates that the figures are more accurately between 350-500 prisoners, hence between 3 and 10 times the official number (Padel, U., *HIV, AIDS and Prison*, London, Prison Reform Trust, 1988, p. 5).

One United States commentator stated that as of October 1987, there were 1,964 AIDS cases among inmates in the 70 United States correctional institutions (including the federal prison system, 50 state prison systems and a sample of 20 city/county jail systems)(Hammett, T.M. *AIDS in Correctional Facilities: Issues and Options*, 3rd edition, Washington D.C., US Department of Justice, 1988). This same author believes that between October 1987 and October 1988 there was a 60% increase, from 1,964 to 3,136 cases, of AIDS (the 1988 figure incorporates 28 city/county jails) and by October 1989, a 72% increase with 5,411 cases (the 1989 figure incorporates 32 city/county jail systems). In fact figures provided show that the increase in cases in the prison population exceeded the increase in the total AIDS cases for the US population at large, which was 50% (Hammett, T. M., and Moini, S., 'HIV/AIDS in U.S. Prisons and Jails: Epidemiology, Policy and Programs' Paper presented at Conference on HIV/AIDS and Prisons, 19-21 November 1990, Melbourne, *supra* note 4, 31-53, at p. 40, Table 1). More recent figures are unavailable.

<sup>14</sup> Hammett, *AIDS in correctional facilities: issues and options*, and Kelley, P. W., Redfield, R. R., Ward, D. L., *et al*, 'Prevalence and incidence of HTLV-111 in a prison', *JAMA*, 1986, 256:2198-2199. Details of AIDS in prisons in 1986 in the United States is covered in Wormser, G. P., 'AIDS in Prisons', in Wormser, G. P., Stahl, R. A., and Bottone, E. J. (eds), *AIDS and Other Manifestations of HIV Infection*, Noyes Publications, New Jersey, 1987, chapter 26, at p. 48-66. For European figures in 1987: Harding, T. W., 'AIDS in prisons' *Lancet*, 1987, 2:1260-1264 where details are provided of the incidence of AIDS in prisons in a number of European countries.

<sup>15</sup> Gardner, K. J., 'Sentenced to Prison, Sentenced to AIDS: The Eighth Amendment Right to be Protected from Prison's Second Death Row' (1988) 92 *Dickinson Law Review*, 863-893, at p. 870.

### 3. RISK FACTORS IN PRISON

As the figures of AIDS and HIV infection within prisons could be regarded as unreliable, it is more prudent to examine the incidence of risk factors in prisons. There is evidence that high-risk activities capable of transmitting HIV, such as non-consensual and consensual sexual activity, drug use and assaults, take place in prisons. It is necessary to consider the incidence of these activities in more detail.

#### SEXUAL ACTIVITY

Studies from as early as 1958 support the theory that homosexual activity takes place in both male and female prisons in the United States. For example, according to Clemmer 40% of prisoners studied had some form of homosexual relationship.<sup>16</sup> By the 1970s, Gagnon<sup>17</sup> indicated a higher figure of between 40-50%. Thomas<sup>18</sup> established that after three years in a maximum-security prison between 80-90% of prisoners were involved in homosexual relationships.

There is little historical data to support the presence of homosexuality within prisons in Australia. Consensual homosexual activity constitutes an offence against prison discipline<sup>19</sup> in Australian prisons despite the fact that outside of prison such conduct is legal in all jurisdictions (with the exception of Tasmania) when occurring in private between consenting adults. There are at least two Australian reported judgements

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<sup>16</sup> Clemmer, D., 'Some aspects of sexual behavior in the prison community', (Proceedings of the American Correctional Society) unpublished, 1958. But Sykes viewed the figure to be approximately 35% (Sykes, J., *The Society of Captives*, USA, Princeton University press, 1958).

<sup>17</sup> Gagnon, reported in Buffum, P. C., *Homosexuality in Prisons*, Washington D.C., US Department of Justice, 1972.

<sup>18</sup> Thomas, H. E., 'Regressive maladaptive behavior in maximum security prisons', (Conference on Prison Homosexuality), USA, unpublished, 1971.

<sup>19</sup> For example, r. 20 *Corrective Services Act Regulations* (1998)(S.A.). As stated in chapter two, unlike drug use very few persons are prosecuted and receive a custodial sentence for homosexual conduct. A significant proportion of homosexual conduct taking place in prison is generally thought to be 'situational' (Goldberg, G., 'Letting Sex out of Prison' (1991) 23/2 *Australian Journal of Forensic Sciences*, 29-37).

which provide evidence of sexual offences being committed within the prison setting.<sup>20</sup>

The occurrence of homosexual activities in prisons appears to be based on factors such as accommodation arrangements (single-cell as opposed to dormitory style and high or low security), the duration of sentence and the extent to which conjugal visits are permitted.<sup>21</sup> The fact that power and domination in the correctional setting are established through sexuality will make homosexual activity difficult to eradicate.<sup>22</sup>

In South Australia, a study, was conducted in 1989 at Yatala Labour Prison to ascertain the prevalence of such activities.<sup>23</sup> The results indicate the degree to which high-risk activities were engaged in at that time. Approximately, thirty-four percent of prisoners admitted that they engaged in occasional anal intercourse and 12% of those prisoners reportedly engaged in unprotected intercourse. The study also revealed that prisoners were uneducated about the risks of acquiring HIV through engaging in high-risk activities.

In addition, non-consensual homosexual conduct such as rape and sexual assault is thought to be widely prevalent and under-reported in the prison environment.<sup>24</sup> In the Yatala study, 19% of prisoners agreed that condoms would be used in rapes.<sup>25</sup> This provides indirect evidence that rapes do occur in that particular prison and hence it is at least arguable that they occur in other Australian prisons.<sup>26</sup>

The extent of non-consensual homosexual activity is better documented in the United States, where one self report study found that 0.6%

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<sup>20</sup> *R v Howie* (1978) Qd R 380 where sodomy was committed by one prisoner on another; *R v Lukic*, a case where one prisoner was forced to engage in oral sex on another (Qld CA 243/92, 29.9.92). In both cases the accused was found guilty as charged.

<sup>21</sup> Hough, A., and Schwartz, D. M., 'AIDS and Prisons - Working Our Way Out of the Maze', Paper presented at Industrial issues Workshop, National Conference on AIDS, 1985.

<sup>22</sup> Thomas, *supra* note 18, at p. 4.

<sup>23</sup> Douglas, *supra* note 1, at pp 61-64.

<sup>24</sup> Gardner, *supra* note 15, at p. 870, citing *United States v Bailey* 444 US 394 (1980), at pp. 597-598 of the judgment.

<sup>25</sup> Douglas, *supra* note 1, at p. 62.

<sup>26</sup> The point has been confirmed by the decision in *L v Commonwealth* where the Northern Territory authorities were found liable for failing to prevent a sexual assault where a prisoner was placed in a cell with two others who were prone to violence (1977) 10 ALR 269. See also the cases, *supra* note 20.

of prison inmates were forced to perform sexual acts with another inmate.<sup>27</sup> Another study found that 28% of inmates had been victims of aggressive sexual encounters.<sup>28</sup> In *United States v Bailey*,<sup>29</sup> the US Supreme Court recognised the presence of homosexual rape in prisons in this judgement of the court:-

We do not live in an ideal world even in America, so far as jail and prison conditions are concerned, the complaints that this Court and every other American Appellate Court, receives almost daily from prisoners about ... homosexual rape ... are not always the mouthings of the malcontent. The Court itself acknowledges that the conditions these respondents complained about do exist.<sup>30</sup>

In the absence of evidence to the contrary, there is no reason to suggest that any Australian prison is immune from either consensual or non-consensual homosexual conduct amongst its inmates. In fact, two features of prisons, their overcrowded and understaffed nature, facilitate these activities and hence the possible transmission of HIV. However, sexual activity is not the only high-risk practice taking place in Australian prisons.

### DRUG USE

IV drug users represent the major risk group for HIV infection in prisons. A sizeable proportion of prisoners have been imprisoned for drug-related offences,<sup>31</sup> or property offences committed with a desire to obtain drugs.<sup>32</sup> Further, the criminal careers of IV drug using prisoners tend to be recidivistic. Hence there are good grounds for believing that, unless

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<sup>27</sup> Nacci, P. L., and Kane, T. R., 'Intimate Sexual Aggression: some Evolving propositions, Empirical Findings and Mitigating Counterforces' in *Gender Issues, Sex Offences and Criminal Justice*, Washington DC, Hayworth Press Inc., 1984

<sup>28</sup> 'Comment, Rape: The Unstated Sentence' (1984) 15 *Pacific Law Journal*, 899, citing Lockwood, D., *Prison Sexual Violence*, 1980, 6-7.

<sup>29</sup> 444 US 394 (1980).

<sup>30</sup> *Ibid*, at p. 421-422.

<sup>31</sup> Johnson-Fitzpatrick, *supra* note 2, found that 32% of a sample of 104 persons imprisoned had committed offences related to drug use. See also Bell, J., Fernandes, D., and Batey, R., 'Heroin users seeking methadone treatment', *Med J Aust*, 1990, 152:361-364.

<sup>32</sup> Dobinson and Ward, *supra* note 3. 40% of a sample of 225 prisoners were tested.

rehabilitated, these prisoners would use drugs within the prison system if available.

It is indisputable that drugs are available in Australian prisons. This has been proven by the occasional cases of criminal charges brought against prison officers and prisoners.<sup>33</sup> Drugs enter the prisons through various sources including contact visits, day release schemes and through prison officers.<sup>34</sup>

The South Australian study confirmed that drugs were available and drug use was occurring within Yatala prison. For example, 37% of prisoners reported their use of IV drugs in that prison.<sup>35</sup> This study also reinforced the conclusion, drawn in previous United States studies, that prisoners are using drugs in a manner which renders transmission of HIV more likely, through shared needles.<sup>36</sup> In fact 93% of prisoners in the Yatala study agreed that if clean needles were available the risk of transmission of HIV would be reduced.<sup>37</sup> Studies of both Western Australian and New South Wales prisons have confirmed that a number of prisoners are regular IV drug users whilst in prison.<sup>38</sup>

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<sup>33</sup> Kirby, M., 'AIDS Strategies and Australian Prisons', Unpublished Paper Presented to The South Australian Justice Administration Foundation, 1990, at p. 17.

<sup>34</sup> Liew, C., 'On the Integrated management of Human Immunodeficiency Virus (HIV) Infection in South Australian Prisons: The Medical Perspective', Paper presented at Conference on HIV/AIDS and Prisons, 19-21 November 1990, Melbourne, *supra* note 4, 143-154, at p. 147.

<sup>35</sup> Douglas, *et al*, 'Risk of transmission of the human immunodeficiency virus in the prison setting', *supra* note 1, at p. 722. Similar levels of needle sharing are confirmed by studies conducted in the United Kingdom prisons (Kennedy, D., Nair, G., Elliot, L., Ditton, J., 'Drug misuse and sharing of needles in Scottish prisons', *BMJ*, 1991, 302: 1507).

<sup>36</sup> Gardner, *supra* note 15, provides details to indicate that a high proportion of US prisoners are past drug users. In addition, she states that these individuals continue to engage in drug use whilst incarcerated (at p. 868). Hammett and Moini, *supra* note 13 report that 'IV drug use is the predominant exposure category' in US prisons (at p. 33)).

<sup>37</sup> Douglas, *supra* note 1, at p. 62.

<sup>38</sup> In Western Australia: Indermaur, D., and Upton, K., 'Alcohol and Drug Use Pattern of Prisoners in Perth' (1988) 21 *Australian and New Zealand Journal of Criminology*, 144-167. Miner, M and Gorta, A., 'Heroin Use in the Lives of Women Prisoners in Australia' (1987) 20 *Australian and New Zealand Journal of Criminology*, 3-15. In New South Wales: Frape, G., *AIDS in Prisons*, Sydney, NSW Dept. of Corrective Services, May, 1985. Frape estimated that 80% of prisoners were using drugs in New South Wales prisons. A 1989 study of New South Wales prisons supported by a Commonwealth AIDS Research Grant (CARG) found that 155 of 209 respondent prisoners (74.2%) reported having injected drugs (of which 31% were amphetamines and 77.4% heroin) at least once while in prison with 78% of those persons stating they injected on five or less occasions per week. 75% of the 155 reported sharing needles (in Wodak, A. D., Shaw, J. M., Gaughwin, M. D., Ross, M., Miller, M., and Gold, J., 'Behind Bars: HIV: risk-taking behaviour of Sydney Male Drug injectors While in

In 1994 a prisoner in an Australian prison was confirmed as the first conclusive case where HIV had been acquired in the prison setting.<sup>39</sup> The mode of transmission is thought to be needle sharing and sexual conduct. The prisoner had been incarcerated permanently between 1980 and 1990. He tested antibody negative in 1987 and then positive in 1989. It is highly unlikely that the prisoner acquired the disease before 1980 given the report of the first antibody test. Even accepting that the antibody test was not as accurate in 1987 as it is in 1994 the lack of presence of HIV in the Australian community in the late 1970s early 1980s would render it unlikely. In addition, the prisoner reported no instance of overseas travel or history of blood transfusion or haemophilia. The second test was taken after symptoms of HIV infection became apparent. This example reveals that high-risk behaviours do take place within prison. Further, the limited opportunities for reducing risk in prisons increases the potential for HIV transmission.<sup>40</sup>

### NON-SEXUAL ASSAULTS

Prisoners are also at some risk of acquiring HIV as a result of non-sexual assaults in prisons, involving fighting and biting. In New South Wales, there were 125 reported assaults between prisoners and 47 assaults by prisoners on prison officers from January to June 1988.<sup>41</sup> However as stated in chapter one, the percentage risk of transmission of HIV through these activities is much less than for either sexual activity or IV drug use.

Australian governments appear to recognise that high-risk activities do take place in Australian prisons. In response, policies have been implemented within Australian prisons to curb the spread of the virus. A number of AIDS-specific guidelines pertaining to HIV in prisons have been set

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Prison', Paper presented at HIV/AIDS and Prisons Conference, 19-21 November 1990, Melbourne, *supra* note 4, 239-245, at pp 240-241.) and also Wodak, A., *AIDS and Intravenous Drug Users*, Unpublished Proceedings of Seminars and of Scientific Sessions. Department of Community Medicine, St. Vincents Hospital, Sydney, 1986, 179-185.

<sup>39</sup> Gerrard, J. G., McGahan S. L., Milliken J. S. *et al*, 'Australia's first Case of AIDS?' *Med J Aust* 1994, 160: 247-250.

<sup>40</sup> A conclusive case of HIV transmission involving an IV drug user within a Scottish prison has been documented (Christie, B., 'HIV outbreak investigated in Scottish jail' *BMJ* 1991, 302: 880).

<sup>41</sup> Scagliotti, L., 'AIDS Education and the Prison System', Report of the Third National AIDS Conference, Canberra, Australian Government Publishing Service, 1988. The prisoner warden who was stabbed with a syringe in Long Bay Jail in 1990 provides evidence of the risks posed to prison warders also (see chapter three and *infra*).

by WHO and also by the Federal Government. The need for the enactment of such guidelines illustrates the precarious position of prisoners within the prison system which came to be accentuated by the presence of HIV infection within the system itself.

#### **4. THE NEED FOR AIDS-SPECIFIC GUIDELINES PERTAINING TO PRISONS**

By 1987, world statistics indicated that many people suffering from HIV or AIDS were passing through institutions of the criminal justice system, particularly the prisons. Questions arose as to how such persons should be treated within such institutions. Evidence of less than adequate conditions for HIV-infected persons in Australia<sup>42</sup> brought to the forefront the question of whether prisoners and in particular HIV-infected prisoners have any enforceable rights which would enable them to demand specific conditions within prisons. Most liberal democratic countries including Australia have domestic prison statutes which provide for general medical treatment of prisoners. In Australia, this is only mandated in three States (New South Wales, Victoria and Queensland) and then only Victoria couches the provision of medical treatment, for example, as a 'right'.<sup>43</sup>

#### **DO PRISONERS HAVE RIGHTS?**

This question of whether provisions such as that contained in the Victorian prison legislation create enforceable obligations raises the issue of the existence and scope of prisoner's rights. The constitutional safeguards which protect prisoners<sup>44</sup> and which are derived in the United States from the Bill of Rights, have no counterpart in Australia. Conditions in Australian prisons are governed by Prisons Acts and Regulations. With the exception of the Victorian legislation, the language in the statutes is not couched in terms of rights or entitlements. The legislation generally concentrates on

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<sup>42</sup> As was aired in Western Australia in the *Report of the Select Committee Appointed to Inquire into the National HIV/AIDS Strategy White Paper*, Perth, Western Australian Government Printer, 1990, at p. 57.

<sup>43</sup> s. 16(1) *Prisons Act* (1952)(N.S.W.); s. 47(1)(f) *Corrections Act* (1986)(Vic.) 'prisoners have the right to have access to reasonable medical care and treatment necessary for the preservation of health'; and s. 13(1) *Corrective Services Act* (1988)(Qld.) 'to provide such medical services as are necessary for welfare'.

<sup>44</sup> set out in note 113 *infra*.

administrative, security and disciplinary matters.<sup>45</sup> Although it has been judicially stated in England 'that prisoners retain all civil rights which are not taken away expressly or by necessary implication'<sup>46</sup> Australian authority has generally not been supportive of the proposition that relevant legislation, where it does exist, confers justiciable rights on prisoners.<sup>47</sup> The judiciary appear to view their role as one of adjudication and disposition, rather than supervision of the treatment of prisoners. It appears that a withdrawal of rights is done in a spirit of 'mutual accommodation' where rights are balanced against needs and goals of prison authorities. However, if courts are reluctant to intervene in prison administration then there is no objective body to assess whether the balancing act is being performed fairly. The existence of prison ombudsmen is not an adequate safeguard as their powers to intervene on behalf of prisoners against prison authorities are limited. In the United States it is apparent that HIV-infected persons have often been the unsuccessful plaintiffs against prison authorities on matters ranging from segregation to medical treatment. The overriding goal of the need to preserve institutional security more often than not, seems to tip the scales in their favour.<sup>48</sup>

There has been judicial recognition in Australia of the fact that prison authorities owe a common law duty of care to their inmates.<sup>49</sup> Hence, prisoners who are unprotected from sexual assault or even transmission of disease could argue that prison authorities have breached their duty of care towards them. There is no recorded case where the failure to provide specific conditions has been relied on as a breach of the duty.<sup>50</sup> Further, the

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<sup>45</sup> Norberry, *supra* note 12.

<sup>46</sup> *Raymond v Honey* [1982] 1 All ER 756 at p. 759 per Wilberforce LJ.

<sup>47</sup> *Flynn v The King* (1949) 79 CLR 1.

<sup>48</sup> Vaid, U., 'Prisons' in Dalton, S., and Yale Law Project' *AIDS and the Law: A New guide for the Public*, New Haven, Yale University Press, 212-225.

<sup>49</sup> *Howard v Jarvis* [1957] 98 CLR 177 where police held responsible for death of person in police lock-up on basis had failed to exercise reasonable care for the safety of the prisoner during the detention. In *L v Commonwealth* (1976) 10 ALR 269, at p. 285, see *supra* note 26, the court held that the common law duty of care owed by prison authorities to prisoners held in their custody included not putting the plaintiff in a cell with prisoners whom they knew or ought to have known were prone to violence.

<sup>50</sup> There is currently an application before the New South Wales Supreme Court against the State of New South Wales over its refusal to permit prisoners to have access to condoms. The prisoners in this case are seeking a mandatory injunction under the *Felons (Civil Proceedings) Act* (1981)(N.S.W.) to force the government to reform its policies. The case is discussed under 'Alternative Strategies' *infra*.



existence of a duty owed is limited by some State legislation which limits legal action against prison authorities.<sup>51</sup> For example, Western Australian and New South Wales legislation provides that no action or claim for damages lies against any person for things done or purported to be done under prison legislation unless it is proved that the act was done 'maliciously and without reasonable or probable cause'.<sup>52</sup> The scope of such provisions has not been adjudicated on<sup>53</sup> but their existence may act as a barrier to potential litigants. There may also be more subtle pressures preventing prisoners from instigating such litigation. These include the limited access to legal aid and widespread reluctance to involve themselves in disputes with their custodians. Rather than alleging that prison authorities owe a duty to provide certain conditions and the failure to do so amounts to a breach of a duty, prisoners have tended to rely on equal opportunities legislation and argue that as HIV-infected persons they are discriminated against in many areas of prison life on the grounds of their status or 'impairment'. Such actions have been successful in Western Australia.<sup>54</sup>

At an international level there are basic human rights documents, such as the *Universal Declaration of Human Rights* (1948) ('UD'), and

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<sup>51</sup> s. 111 *Prisons Act* (1981)(W.A.); s. 46 *Prisons Act* (1952)(NSW); s. 62(1) *Corrective Services Act* (1988)(Qld.). *L v Commonwealth* (supra note 49) concerned Northern Territory legislation which did not contain such a provision limiting common law claims.

<sup>52</sup> s. 111 *Prisons Act* (1981)(W.A.); s. 46 *Prisons Act* (1952)(NSW). Such legislation would also prevent prison warders from taking action against prison authorities where HIV is transmitted during employment. The Intergovernmental Committee on AIDS Legal Working Party in its report *Employment Law and HIV/AIDS* (1991) observed that: 'under both common law and statutory workers' compensation schemes, a worker's access to compensation for non-economic loss where they are infected with HIV but not symptomatic, is restricted or non-existent' (at p. 18). Australia's only known case of HIV transmission inflicted on a prison warder by a prisoner settled in September 1994 when the New South Wales Department of Corrective Services agreed to settle the claim. It is not documented whether the Department admitted liability or whether it was a workers' compensation claim or a claim for general damages under a duty of care (Anon, 'Stabbed warder says HIV a bonus', *West Australian*, September 7 1994, p. 11). In this example, the duty of care could be held not to be limited by s. 46 of the New South Wales *Prisons Act* (1952) given that the injury was done 'maliciously and without reasonable or probable cause'.

<sup>53</sup> In *A Complainant & Anor v The State of Western Australia* unreported judgment Equal Opportunities Tribunal, No. 7 of 1992 and No. 6 of 1993, 15th July 1994, the Tribunal specifically stated that the prison authorities could not rely on section 111 of the *Prison Act* (1981)(W.A.) to exempt them from liability under the *Equal Opportunities Act* (1984) in that State because the latter Act was more specific and enacted later in time than the former.

<sup>54</sup> *Hoddy v Executive Director Department of Corrective Services*, unreported judgment Equal Opportunity Tribunal, No. 8, December 18 1991; *A Complainant & Anor v The State of Western Australia* (supra note 53). Under such legislation it matters not that the party in control of services and facilities may have been trying to protect the complainants from harm. The question is whether authorities acted pursuant to an impermissible consideration, namely, the presence of an impairment known as HIV. These cases are discussed later in the chapter.

Covenants such as the *International Covenant of Civil and Political Rights* (1966) ('ICCPR'). These documents contain provisions that, protect against cruel and unusual punishment<sup>55</sup>, preserve a right to privacy<sup>56</sup>, provide for freedom from discrimination<sup>57</sup> and provide for the right to medical treatment.<sup>58</sup> These human rights covenants have been incorporated into domestic Australian law, however, only in relation to selected Commonwealth legislation. Hence, the Human Rights Commission is only empowered to investigate a complaint when it originates from a federal prisoner. This leaves prisoners in State controlled prison systems unprotected until they have exhausted all domestic remedies.<sup>59</sup> At that point an application could be made to international human rights bodies such as the United Nations Human Rights Committee<sup>60</sup> but the protracted nature of such proceedings would unlikely find favour with an HIV-infected prisoner.

With respect to prisoners specifically there are the United Nations *Standard Minimum Rules for the Treatment of Prisoners* (1973), which provide standards of custody and medical care. In Australia, there are *Standard Guidelines for Corrections* which were drafted in 1989 and are based on the UN *Standard Minimum Rules for the Treatment of Prisoners*. They protect against discrimination<sup>61</sup> and preserve the rights of prisoners

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<sup>55</sup> Art. 5, UD; Art. 7, ICCPR.

<sup>56</sup> Art. 17, ICCPR.

<sup>57</sup> Art. 26, ICCPR.

<sup>58</sup> Art. 25, UD; Art. 10, ICCPR.

<sup>59</sup> which would include any administrative remedies for judicial review. For example, if a prisoner was charged with an offence against prison discipline and evidence for establishing the offence was not collected in accordance with Prison Rules, a failure to follow mandatory procedural protections in prison disciplinary schemes can render decisions susceptible to judicial review, despite the lack of a general right of appeal. Hence the obligation to act in accordance with such rules are enforceable (*Bromley v Dawes* (No. 1) (1983) 10 A Crim R 98). However, it is thought that there is a distinction between punitive decisions and management decisions such as administrative segregation. The latter are thought to be outside the range of judicial review remedies and are more likely to benefit from a judicial acceptance of management justifications tendered by prison administrators (*McEvoy v Lobban* [1990] 2 Qd R 235).

<sup>60</sup> As was the procedure adopted in *Toonen v Australia* CCPR/C/50/D/488/1992 where Toonen challenged the validity of sections 122-123 the Tasmanian Criminal Code which prohibits sexual practices in private between consenting adults. The Commission found that Code provisions to be in breach Article 17(1) (which protects privacy including sexual privacy) of the ICCPR and thus Australia's human rights obligations. The effective remedy would be the repeal of sections 122-123 but the Tasmanian Government has refused to change the law in response to the UN decision (Alexander, M., 'Tasmanian gay activist wins in the UN' (1994) 5(2) *HIV/AIDS Legal Link Newsletter*, 1, 9).

isolated for health reasons.<sup>62</sup> Neither of these documents create legal obligations.

There are however some AIDS-specific guidelines which were developed in the late 1980s. The World Health Organisation (WHO) has set down guidelines for the treatment of HIV-infected prisoners within prisons. The Australian Federal Government also responded to the pandemic by the release of the *National HIV/AIDS Strategy*.<sup>63</sup> The Strategy devotes a section to the prevention of HIV within prisons. These guidelines warrant some examination.

### WORLD HEALTH ORGANISATION GUIDELINES

In 1987 WHO held a Consultation in Geneva on the 'Prevention and Control of AIDS in Prisons'. This involved experts in wide ranging areas from 26 countries. Following that Consultation, a 'consensus statement' was issued.<sup>64</sup> The statement recognises that HIV infection brings to the forefront the notion that there is a need to improve the overall hygiene of prison environments and notes that high-risk activities are currently taking place in prisons in many countries. The statement makes it clear that policies applied to the general community should apply equally to prisons. Prison guidelines are to include the following concepts:

C. ...

2. Prisoners should be treated in a manner similar to other members of the community with the same right of access to:

a. educational programs ... [relevant to HIV infection and AIDS],

b. testing for HIV on prisoner request, with confidentiality of results, timely pre- and post-test counselling, ...

c. medical, nursing, inpatient and outpatient services of the same quality as those for AIDS patients in the community at large;

d. information on treatment programs and the freedom to refuse such treatment.

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<sup>61</sup> para. 1.80.

<sup>62</sup> para. 5.70.

<sup>63</sup> Commonwealth of Australia, *National HIV/AIDS Strategy: a policy information paper*, Canberra, Australian Government Publishing Service, 1989.

<sup>64</sup> reproduced in Carr, *supra* note 5, at pp.13-14.

3. In addition, prisoners with AIDS should be considered for compassionate early release to die in dignity and freedom.

4. Prisoners should not be subjected to discriminatory practices relating to HIV infection or AIDS such as involuntary testing, segregation or isolation, except when required for the prisoner's own well-being. ...

D. ... Careful consideration should be given to making condoms available in the interests of disease prevention. It is also recognised that, within some lower-security correctional facilities, the practicability of making sterile needles available is worthy of further study.

E. Decisions regarding testing and/or screening should be considered in the context of informed consent, the ability to maintain confidentiality and the provision of positive assistance to affected individuals. ...

These guidelines, which although they are not legally binding,<sup>65</sup> do provide a guide for State and Territory governments attempting to adopt uniform prison policy in relation to HIV/AIDS. In the absence of judicially recognised rights and the perceived difficulty in enforcing a common law duty of care against prison authorities, the present writer believes that the spirit of such provisions should be adhered to in policies set up to curb the spread of HIV in prisons and to ensure that HIV-infected inmates are reasonably catered for. The *National HIV/AIDS Strategy* also provides implicit recognition of the need for establishing guidelines in this area.

#### NATIONAL HIV/AIDS STRATEGY

The Australian Federal Government has also attempted to guide State and Territory governments by the production of the *National HIV/AIDS Strategy*. The release of this document was the end stage of the work of a number of intergovernmental working parties in the area of HIV/AIDS. The final drafting of the document took into account submissions received in response to an earlier document circulated for public comment entitled A

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<sup>65</sup> Although such guidelines do not create legally enforceable rights it is significant that the provisions of the *National HIV/AIDS strategy* (supra note 63), the WHO guidelines and the conclusions of the Heilpern and Egger report (supra note 6) were recognised as policy documents containing provisions that were to be considered in tandem with provisions of the *Prisons Act* (1981)(W.A.) in the 1994 case before the Western Australian Equal Opportunity Tribunal (*A Complainant & Anor v The State of Western Australia* (supra note 53).

*time to care; A time to act: a strategy for all Australians.* <sup>66</sup> Given that the Strategy is largely based on the opinions of representative public groups in various areas, it was expected that governments would develop policies and enact legislation according to the spirit and terms of the Strategy. In doing so a uniform approach to curbing the spread of HIV and catering for its presence within society, would be achieved. Given that the principles are general it is acknowledged by the present writer that they may not apply in exceptional circumstances. Such circumstances may arise within the prison system. However, the *National HIV/AIDS Strategy* acknowledges the presence of HIV-infected persons in the prison system and also accepts that high-risk behaviours take place within Australian prisons. <sup>67</sup> In a 1994 Western Australian decision, the Equal Opportunities Tribunal held that 'the National Strategy has a bearing upon the standards of care to be observed by prison authorities'. <sup>68</sup> Hence, while not legally binding these guidelines are recognised as an important benchmark by which practices are to be examined. Their existence allowed the complainants counsel to mount a stronger case against the Prison Authorities. <sup>69</sup> The relevant provisions of the Strategy will be focused on when examining both the policies developed to curb the spread of HIV within prisons and the impact that those policies may have on HIV-infected persons:

## **5. POLICIES WITHIN AUSTRALIAN PRISONS TO REDUCE THE SPREAD OF HIV**

In response to evidence of the likelihood of the spread of HIV in Australian prisons, States and Territories implemented a number of policies to address the situation. This section reviews these policies and in particular the impact such policies have on HIV-infected inmates.

The early response to curbing the spread of HIV within Australian prisons was to identify the infected and then to isolate those persons suffering from HIV. This task was performed haphazardly across the States and

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<sup>66</sup> Commonwealth of Australia, Canberra, Australian Government Publishing Service, 1988.

<sup>67</sup> *supra* note 63, para. 5.8.1.

<sup>68</sup> in *A Complainant & Anor v The State of Western Australia*, *supra* note 53, at p. 62.

<sup>69</sup> Here the complainants argued that segregation on the grounds of HIV status led to discriminatory practices and was detrimental to their health. The fact that segregation was not encouraged in the *National HIV/AIDS Strategy* was regarded as an important consideration when considering the ambiguity of Rule 3Q of WA Prison Policy, the rule which the respondents argued allowed segregation (*Ibid*, at pp. 62-64).

Territories with little uniformity in policies. This lack of uniformity militated against its success as a scheme designed to curb the spread of HIV within prisons. The scheme was also accompanied by a failure to accept at an official level that high-risk practices were taking place within prisons. The identification process was achieved by testing, albeit in a piecemeal manner, and isolation by segregation.

### COMPULSORY TESTING

Compulsory testing of prisoners is a strategy being used to reduce the incidence of HIV/AIDS in Australian prisons. As of 1994, all Australian States and Territories have either passed legislation or have developed policies which enable testing of prisoners. Compulsory programmes operate in South Australia, Tasmania, Queensland, Northern Territory, Australian Capital Territory and New South Wales. In Victoria and Western Australia testing is voluntary, with an exception in the latter jurisdiction relating to high-risk prisoners. In the States and Territories where testing is compulsory, testing is initially conducted at reception with re-testing after three months. In New South Wales re-testing is on exit. Only in Queensland is testing comprehensive: in addition to the testing on entry and after three months, prisoners are also re-tested at twelve month intervals and four - two weeks prior to release.<sup>70</sup>

The enactment of legislation for compulsory testing of prisoners could be described as 'knee-jerk' legislation. Indeed, many States (with the exception of New South Wales<sup>71</sup>) had passed such legislation before the WHO Statement on the Prevention and Control of AIDS in Prisons was released in July 1987 and before the release of the Federal Government's *National HIV/AIDS Strategy* in 1989. Under the WHO recommendations only voluntary testing of prisoners is supported. The Australian Strategy argues that current circumstances warrant the testing of prisoners on exit but that the consent of the prisoner should be sought and counselling should be available.<sup>72</sup> The implementation of testing strategies illustrate the politics

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<sup>70</sup> Commonwealth Government, *National HIV/AIDS Evaluation 1991-1992 State Stories Report*, Canberra, Australian Government Publishing Service, 1993, at pp. 64-67.

<sup>71</sup> New South Wales passed legislation on compulsory testing in 1990, *supra* note 7.

<sup>72</sup> *supra* note 63, para. 5.8.6.

surrounding many debates that have arisen in the prison context. These debates will be referred to in the course of this chapter where relevant.

The question that has been debated at some length, is whether testing needs to be compulsory. In chapter five, arguments were presented for and against compulsory testing. It was concluded that the compulsory testing of a small population may be justified in some circumstances. The dispute concerns whether the prison system is such a population. There are some specific aspects of this issue which apply to prisoners and hence the arguments for testing prisoners as a special population will be set down and then evaluated.

First, it could be argued, given that high-risk practices are taking place in prisons and prisoners enter a potentially infectious environment when received into prison, that compulsory testing schemes may be justified in terms of the protection of healthy inmates. Second, compulsory testing will help to identify the prevalence of HIV within prisons. The third argument or justification is that, by the introduction of such a scheme, infected persons are identified, precautions can be taken, treatment can be administered and special programmes of counselling can be directed at those prisoners. The fourth justification for compulsory testing in prisons is that it will prevent HIV spreading to the wider community in the future.

Some concerns may be raised as to the validity of the four points above. It was argued in chapter five that testing for the protection of a person other than the person being tested is never justifiable. This ground has led to a virtual return to voluntary testing in the United States prisons systems.<sup>73</sup> It has been argued that mass screening should be avoided because its coerciveness conflicts with the rights of the individuals not to be subjected to medical procedures without their voluntary, informed consent and threatens to deprive individuals of their rights to privacy.<sup>74</sup> This factor has been regarded as particularly acute in the prison setting. The New South Wales Privacy Committee has in 1994 called upon the New South Wales government to abandon its policy of forcibly testing prisoners for HIV primarily on privacy grounds.<sup>75</sup>

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<sup>73</sup> Hammett, and Moini, *supra* note 13, at p. 35.

<sup>74</sup> Joint Sub-Committee on AIDS in the Criminal Justice System of the Committee on Corrections and the Committee on Criminal Justice Operations and Budget, 'AIDS and the Criminal justice System: A Preliminary Report and Recommendations' (1987) 42/7 *The Record of the Bar Association of New York*, 901-923, at p. 911.

<sup>75</sup> New South Wales Privacy Committee, *Private Lives and Public Health Privacy: Guidelines for HIV Testing*, Sydney, 1993.

The merit in the second argument is also dubious. The present difficulty of ascertaining prevalence of HIV in prisons across Australia due to the alleged haphazard testing and re-testing policies <sup>76</sup> leads one to question whether a compulsory scheme would assist in obtaining that data. As noted in chapter five, prevalence alone is not a justification for a compulsory testing scheme generally. Prevalence data of HIV/AIDS infection in prisons is unlikely to operate to curb the spread of the disease on its own without specific measures being introduced. There needs to be more surveillance and/or prevention of the activities that transmit the virus, such as non-consensual rape.

As to the third point, on the use of precautions and the need for identification and treatment of infected persons, it can only be stated that precautions should always be taken, prevention being the only hope where there is no cure for a disease. In addition, there is no special treatment which could be provided to an HIV-infected person to warrant him or her being identified in a compulsory manner.

Testing is not an end in itself and mere knowledge of antibody status will not prevent the transmission of the virus and protect healthy inmates. A study in Oregon concluded that there was no evidence that compulsory testing of prisoners had an effect on behaviour change. In fact, the study showed that there was mounting evidence that voluntary testing combined with counselling does change behaviour. <sup>77</sup> In Victoria, voluntary testing in prisons attracts a 98% acceptance rate. <sup>78</sup> If that is so, then it may be possible to argue that if people wish to discover their antibody status then they may also wish to alter their behaviour if a positive result is obtained, or that they are at least more amenable to counselling towards behavioural change than a person who is ordered to undergo a test.

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<sup>76</sup> See studies listed in footnote 6.

<sup>77</sup> Andrus, J., *et al.* 'HIV testing in Prisoners: Is Mandatory Testing Mandatory?' *Am J Pub Health*, 1989, 79:840, at p. 842.

<sup>78</sup> Clunies-Ross, T., 'Management of HIV in Community Based Corrections', Paper Presented at HIV/AIDS in Prison Conference, 19-21 November 1990, Melbourne, *supra* note 4, 273-280, at p. 297. The Victorian Office of Corrections adopted a Correctional Philosophy. This contained 8 guiding principles. One of these principles, 'Prisoners with HIV should not be further punished while in prison', could lie at the heart of the voluntary system. The voluntary system established in 1985 is still maintained with a 98% compliance rate (Commonwealth Government, *State Stories*, *supra* note 70, at p. 74).

In South Australia it is reported, that the voluntary system formerly in place had a 70% compliance rate (SA Department of Health, *South Australia's AIDS Strategy*, 1987, at p. 10).



It is only the fourth justification, i.e. preventing the spread of disease within the community, that is readily defensible. If transmission of HIV within prisons is probable because of the environmental conditions and the presence of sexual assaults then there is a need to prevent transmission to the wider community. However, testing alone will not achieve that end. Other preventative measures such as counselling and education would need to be adopted in combination with testing. There is some danger in basing a testing policy on mere speculation that inmates infected with HIV will act in a manner which may transmit the virus to others upon their release from prison.

As with testing in other circumstances, compulsory testing in prisons has the potential to be highly costly as prisoners would have to be repeatedly tested, especially since new prisoners enter the system at a rapid rate. Also, the tests are not 100% reliable.<sup>79</sup> This may bring anxiety to the person tested and also provide a misleading picture of the prevalence of HIV within the prison community. In addition, the general concerns as to breaches of confidentiality that were addressed when considering compulsory testing in general also arise when considering testing of a specific population such as prisoners. Safeguards against possible breaches would need to be set in place. Policy makers would have to decide what uses would be made of the tests and who would receive information regarding the results. Finally, any testing scheme must have as a concomitant a well-devised plan for housing persons who test positive.

It is necessary to examine whether testing schemes have been mindful of all these considerations. By focusing on State and Territory legislation and policy, it will be examined whether these jurisdictions adhere to the 1987 World Health Organisation guidelines. The examination will first focus on pre-1987 testing procedures, and second post-1987 testing procedures. Such an examination will also provide insights into the political processes that have been instrumental in the development of legislation in this arena.

#### (i) Pre-1987 Testing Policies

##### *Northern Territory*

Section 75(2) of the *Prisons (Correctional Services) Amendment Act (1985)(N.T.)* introduced compulsory testing of blood and bodily secretions

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<sup>79</sup> as discussed in chapter five, at pp. 205-206.

for all prisoners on entry to prison. This legislation is still in force in the Territory and does not specifically relate to HIV infection. Section 75(3) allows officers to use such force as is necessary to ensure that samples are taken. An officer or person exercising such power is exempt from civil or criminal action. The legislation makes no provision for possible breaches of confidentiality by prisoners and prison staff and there is no reference to the need for pre- and post-test counselling.

### *Queensland*

Queensland implemented compulsory HIV testing for every prisoner under the *Prisons (Special Medical) Regulations* (1986). Section 4 of the regulations allowed persons taking samples to use such force as is reasonably necessary to ensure that the blood is taken. A prisoner who refused to submit committed an offence against discipline. Section 7(2) required that in the case of a positive result, notice be given to the Superintendent of the prison, the Health Department and the prisoner. There was no reference to what would be the fate of such a notice. This statute did contain some confidentiality provisions and created an offence against discipline for prisoners who gave information which may identify whether a prisoner suffered from HIV. Prison wardens or other officials who divulged confidential details about a prisoner's infected status were subject to a penalty of \$200.00.

### *Western Australia*

Section 39 of the *Prisons Act* (1981)(W.A.) enabled medical examinations to be performed with such 'force as is reasonably necessary for the purpose'. Medical treatment could be imposed if the life or health of any prisoner or other person (which could conceivably include staff, inmates and visitors) would be likely to be endangered by the refusal of an inmate to submit to treatment.<sup>80</sup> The term 'medical examination' is not defined. It is doubtful whether it would be taken to include HIV testing. There is nothing in the legislation specifically referring to confidentiality or counselling with respect to test results, although medical officers are required to keep medical

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<sup>80</sup> s. 45 and s. 39(b) authorise such testing on admission.

records confidential.<sup>81</sup> A policy of HIV testing for all prisoners "known or suspected" of being homosexuals or drug users was introduced in 1985.<sup>82</sup> It is not clear upon what grounds or criteria a person becomes 'suspected' of being a homosexual or drug user. The risk level is based on police and medical records.<sup>83</sup> If a person who is suspected to be high-risk refuses to undergo testing they can be medically isolated in the prison.<sup>84</sup> The policy which exists in 1994, is potentially discriminatory, given that studies suggest that many homosexual encounters in prison involve persons who normally are heterosexual on the 'outside'.<sup>85</sup>

### *Tasmania*

In Tasmania, a 1987 amendment to section 17 of the *Prison Act* (1977) by the *Prison Amendment Act* (1987) provided for the selective testing of both long-term and remand prisoners where the life or health of the prisoner, other prisoners or detainees, or a prison officer is 'likely to be endangered or seriously prejudiced by the failure of the prisoner or detainee to undergo medical treatment or medical tests'.<sup>86</sup> The term 'medical test' was not defined as including HIV testing although it did include taking blood and body secretion samples for the purpose of assessing the physical and mental health of a person.<sup>87</sup>

These testing provisions have been criticised because they do not appear to provide adequate protection against possible breaches of confidentiality with regard to test results.<sup>88</sup> The Act specifically allows officers

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<sup>81</sup> s. 39(c).

<sup>82</sup> Heilpern and Egger, *supra* note 6, at p. 32.

<sup>83</sup> Commonwealth Government, *State Stories*, *supra* note 70, at p. 45.

<sup>84</sup> This is contained in Executive Directors Rule 3Q passed pursuant to section 35 of the *Prisons Act* (1981)(W.A.).

<sup>85</sup> Thomas, *supra* note 18 and Goldberg, *supra* note 19.

<sup>86</sup> s. 3(a)(b).

<sup>87</sup> s.17(6).

<sup>88</sup> Patmore, P., 'AIDS Tests for Tasmanian Prisoners: A Manual for Discrimination?', (1987) 12/6 *Legal Service Bulletin*, 272-273. Patmore concluded that 'the Bill [now an Act] displays a frightening lack of logic and understanding of the AIDS problem as it relates to prisoners. If enacted, it will create more problems than it is supposed to solve by inevitably leading to prejudicial treatment and stigmatisation of prisoners.' See also media releases, 'Opposition slams compulsory AIDS tests for prisoners', *The Mercury*, October 29 1988.

to disclose such information for the purpose of performing official functions but does not specify what official functions might require such disclosure.<sup>89</sup> Another ground for criticism has been that the Act does not provide, for the immunity from legal liability for doctors who administer a test without the prisoners consent. Further, the Act does not require that antibody positive prisoners be notified of their HIV status.<sup>90</sup> Also, none of the provisions make any reference to the need for counselling of prisoners prior to testing.

### *Victoria*

In Victoria, section 29 of the *Corrections Act* (1986) provides for testing of blood and bodily secretions as soon as a prisoner is received into prison. This legislation is not AIDS-specific and appears to have a discretionary tone in relation to testing. For example, 'the principal medical officer may direct the prisoner to submit to medical tests.' Peter Harmsworth, Director-General, Office of Corrections stresses that: 'our testing policy is totally voluntary'.<sup>91</sup>

The Victorian statute protects against breaches of confidentiality of information relating to test results by prison officers.<sup>92</sup>

### *New South Wales and South Australia*

New South Wales and South Australia both introduced a 'voluntary testing' scheme in 1985.<sup>93</sup> However, in New South Wales, high-risk prisoners were reputed to be refusing blood tests because of harassment by warders and the lack of confidentiality in the prison system. Further, the consequences of a positive result meant that HIV-infected persons were segregated and transferred to the Malabar Assessment Unit at Long Bay Jail in New South Wales.<sup>94</sup> The Unit has since been closed due to increasing

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<sup>89</sup> s.17(4).

<sup>90</sup> Patmore, *supra* note 88.

<sup>91</sup> Harmsworth, P., 'HIV/AIDS in the Victorian Prison System', Paper presented to Conference on HIV/AIDS in Prison, 19-21 November 1990, Melbourne, *supra* note 4, 125-132, at p. 128.

<sup>92</sup> s. 30(1)(2).

<sup>93</sup> Carr, *supra* note 5, at p. 10.

speculation that breaches of confidentiality within the unit were detrimental to the health of infected prisoners.

An analysis of the compulsory testing legislation enacted at the beginning of the 'AIDS crisis' reveals that testing was not for the benefit of the prisoner but for the purpose of identifying infected prisoners to staff and other prisoners. It seems somewhat illogical to test prisoners and then not to segregate HIV-infected prisoners from other prisoners as has occurred in some State and Territory prison systems. However, segregation may not have been appropriate for short-term prisoners. Notwithstanding this latter point, the failure to segregate after testing arguably suggests that mere identification was an overriding aim in the testing. The legislation may have been implemented as a political measure perhaps to placate staff or the various State Departments of Correction. But little was done to increase knowledge about HIV infection.<sup>95</sup> Overall, early legislation carried few confidentiality provisions and did not impose counselling requirements now medically encouraged as a prelude to testing and mandated under Australian public health legislation.<sup>96</sup>

An analysis of some of these State and Territory provisions and policies would tend to confirm that the requirements of the WHO 'consensus statement' with respect to testing were not observed by the pre-1987 testing legislation. For example, any compulsory scheme such as that operating in the Northern Territory, Queensland and Tasmania offend the basic tenet of the statement which endorses voluntary and informed testing only.<sup>97</sup> In addition, Paragraph E. of the 'statement' which reads 'Decisions regarding testing and/or screening should be considered in the context ... the ability to maintain confidentiality ...' was not adopted in those States and Territories, such as Northern Territory and Tasmania, with compulsory testing schemes, or those States with voluntary schemes, such as Western Australia and New South Wales, where confidentiality of test results was not mandated.

These deviations from suggested policy might, be defended on the ground that the provisions were set in place prior to 1987 when the WHO

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<sup>94</sup> Yabsley, M., 'Government Prisons Policy', written in 1988, but appearing in *Civil Liberty*, No. 136, 1990, 3-8.

<sup>95</sup> Carr, *supra* note 5, at p. 9.

<sup>96</sup> as covered in chapter five. For example, in Victoria, before detention orders are issued for recalcitrant persons, counselling must have been attempted.

<sup>97</sup> paras. C 2 (b).

'consensus statement' was released. A number of the statutory provisions considered above, namely, Queensland's and South Australia's were amended during 1987 and early 1988. The Tasmanian legislation was amended in 1993. The amended provisions will be set out below. As neither the Northern Territory nor Western Australia have amended their legislation in any significant effect these two jurisdictions will not be covered.

## (ii) Post-1987 testing Policies

### *Queensland*

In Queensland, the AIDS-specific legislation was repealed following the passage of the *Corrective Services Regulations* (1989) under the *Corrective Services Act* (1988). Under section 48(4) of this Act the general manager of a prison may authorise a medical officer to take samples of a prisoner's blood if he or she believes on reasonable grounds that the sample may afford evidence of the commission of an offence. Under Section 50(2)(b), whenever a medical examination is carried out, a medical officer may for the purpose of any examination or treatment 'take samples of a prisoner's blood and any other bodily substance ...'. Only under section 48 is it specifically stated that the results of any test will be furnished to the prisoner. Hence, even though section 50 specifically pertains to testing on entry it does not provide that a prisoner will receive his or her results. The difference between these sections and the prior regulation is that they are no longer AIDS-specific. It is significant though that the new amendments contain no reference to counselling. The only provisions relating to confidentiality apply to medical practitioners.<sup>98</sup> However, the *Corrective Services (Administration) Act* (1988) also forbids persons within prisons from releasing information acquired in the course of official functions unless required by legislation or a court of law.<sup>99</sup>

The 1990 Stir Report, recommended that compulsory testing should continue in Queensland, provided it is complemented by adequate information, pre-and post-test counselling, training and resources for both inmates and correctional staff. Inmates should be advised of their results promptly irrespective of outcome and principles of confidentiality should be

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<sup>98</sup> s. 50(5)(a).

<sup>99</sup> s. 61(1)

strictly observed.<sup>100</sup> Implementation of these recommendations has commenced. For example, counselling is a requirement listed in Rule 34 of the Queensland Corrective Services Commission. This rule was passed in 1991.<sup>101</sup> In 1994, Queensland has the most stringent testing policy of all Australian jurisdictions given that testing occurs at admission, after three months, yearly and prior to release.<sup>102</sup>

### *South Australia*

In 1987 a compulsory blood testing scheme for all persons in custody for more than 7 days was introduced.<sup>103</sup> The policy requires pre- and post-test counselling to be offered in conjunction with testing. In South Australia in 1988, a special provision requiring the medical examination of prisoners was inserted by amending the *Corrective Services Act* (1982). Section 65(1) states that a Permanent Head can, for purposes of assessing prisoners or preventing or containing the spread of disease within a correctional facility, direct all prisoners of a class, or particular prisoners, to undergo such medical examinations or tests as specified. Section 65(2) provides that prisoners must not hinder or obstruct a medical practitioner carrying out such medical examinations or tests.

### *New South Wales*

Prior to 1988 in New South Wales a number of testing schemes for prisoners were considered. These included voluntary, anonymous and compulsory testing programmes. New South Wales testing proposals can be tied to specific incidents involving either officer unrest or prisoner misbehaviour. For example, the move towards a compulsory system in New South Wales which was achieved in November 1990 was fuelled by the

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<sup>100</sup> Prisoner and Family Support Association, *The Stir Report: HIV Minimisation Strategies for Queensland Correctional Centres*, Prisoner and Family Support Association, Queensland, 1990, at p. 3.

<sup>101</sup> Commonwealth Government, *State Stories*, *supra* note 70, at p. 67.

<sup>102</sup> Roughley, D., 'Queensland Prisons and the Transmission of HIV infection' *Criminology Australia*, 1993, at p. 26.

<sup>103</sup> Bloor, A., 'Managing HIV Prisoners in an Integrated Setting - Some Successes and Failures', Paper presented at HIV/AIDS in Prison Conference 19-21 November 1990, Melbourne, *supra* note 4, 133-142, at p. 135.

syringe attack on a prison officer at Long Bay jail by a prisoner in July 1990.  
<sup>104</sup> The fact that the officer was later found to be seropositive as a result of the attack added to the debate.

The New South Wales scheme of compulsory testing on discharge is within the terms of the *National HIV/AIDS Strategy*.<sup>105</sup> Due to the presence of the 'window period' in HIV infection, it will be necessary for prisoners to submit to testing at any time.<sup>106</sup> However, this was not seen as necessary in the *National HIV/AIDS Strategy* even though the Federal Government must have been aware of this characteristic of HIV-infection. Regulation 14A(1) of the *Prisons (General) Regulation* (1989) sets out to whom information as to prisoner HIV antibody status will be made available. However, the grounds upon which these persons might be informed is not adequately dealt with by the wording of regulation 14A(2), which states that test results must not be disclosed except for the purpose of exercising the functions of that office. Far from guaranteeing confidentiality the Act as a whole provides for disclosure. It does not lay down the need for counselling or education to accompany such testing and ignores the fact that testing alone achieves nothing. If testing was to have these backups it should have been provided for in the legislation. This will ensure that such safeguards will be implemented. The failure to guarantee confidentiality and provide for counselling contradicts the WHO 'consensus statement'.

### *Tasmania*

In 1993 the *HIV/AIDS Preventative Measures Act* was passed which amended the *Prison Act*. This legislation provides for both pre- and post-test counselling.<sup>107</sup> Hence, the Tasmanian government is acting in accordance with the *National HIV/AIDS Strategy*, which stresses that HIV testing be carried out in the context of pre- and post-test counselling.<sup>108</sup>

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<sup>104</sup> This case was detailed in chapter three, footnote 114. The prisoner died before criminal charges of attempted murder could be heard. The warder has successfully obtained compensation from the Department of Corrective Services (*supra* note 52). It is unclear whether the Department admitted that it had failed in its duty to provide a safe system of work.

<sup>105</sup> para. 5.8.6, *supra* note 63; Yabsley, M., 'Compulsory Testing and Integration' (1991) *Criminology Australia*, 17-18 and 22, at pp. 21-22.

<sup>106</sup> reg. 34A1 *Prisons (General) Regulations* (1989).

<sup>107</sup> ss. 14, 15.

<sup>108</sup> *supra* note 63, para. 5.2.17.



However, the Tasmanian legislation assumes that the rights of prisoners and detainees are limited with respect to the refusal of HIV testing. For example, section 17A(3) states that 'if a prisoner or detainee refuses to undergo an HIV test after being counselled, the Director may take such steps as are necessary to ensure ... that the prisoner or detainee undergoes an HIV test; ...'. While it is arguable that prisoners do not have the same rights and claims as the community in general because they are modified by the necessary conditions of imprisonment it is not correct that a detainee or remand prisoner, who may not yet be convicted of an offence, should have his or right to refuse testing curtailed by statute. As Victoria and Tasmania have specifically addressed the issue of HIV testing of suspected offenders and mandated that a court order is necessary before carrying out any such test, then there is an inconsistency in the Tasmanian legislation when applied to detainees.<sup>109</sup>

### *Victoria*

While the voluntary testing scheme commenced in 1986 still operates in Victoria, there has been a return to setting down policy through legislation. Section 120A of the *Health (Infectious Diseases) Act* (1991) provides for the compulsory testing of a person who may have transmitted a specified infectious disease to a 'custodian' (which would include a prison officer or police officer, by the definition set down in section 118(c)). A prisoner who assaulted a prison officer could be subject to this provision. However, the legislation only allows testing in these circumstances following an application made to a Magistrate for a court order.<sup>110</sup>

### ACCOMMODATION POLICIES

Testing for HIV raises the question of placement of confirmed HIV-infected persons. The issue is whether seropositive prisoners can be realistically returned to the general prison population or segregated. The accommodation policies adopted by Australia in prisons in response to the AIDS epidemic will be addressed and discussed in this section.

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<sup>109</sup> ss 6-19 of the *HIV/AIDS Preventative Measures Act* are said to apply to prisoners and detainees (s. 46).

<sup>110</sup> This legislation has been covered in chapter six, pp. 231-233.

## (i) Segregation

Segregation is one of the ways to prevent transmission of HIV. It is also designed to protect infected persons from violent episodes by other prisoners, and the healthy inmate from the HIV-infected sexual predator. It has been argued that all sexual predators should be segregated.<sup>111</sup> Segregation policy seems to co-exist with compulsory testing schemes.

Segregation may amount to double punishment and may result in a loss of privileges and breach of confidentiality. Experience from Australia<sup>112</sup> and the United States has shown that the cost in both human and financial terms has been high. US courts have, however, been divided as to whether the failure to segregate is a violation of the Eighth Amendment to the US Constitution, in that healthy inmates are not protected or that segregating prisoners amounts to cruel and unusual punishment because a loss of privileges results and prisoner's rights are violated under the First, Eighth and Fourteenth Amendments.<sup>113</sup> Segregation also undermines educational programmes by suggesting to prisoners that HIV can be spread by social contact.

The World Health Organisation recommended against segregation in the 'consensus statement' except for the patient's benefit.<sup>114</sup> The

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<sup>111</sup> Vaid, U., 'Prisoners and AIDS: Facts, Myths and Problems', AIDS Law Sourcebook, Yale, 1986.

<sup>112</sup> For example in *A Complainant & Anor v The State of Western Australia* (*supra* note 53) medical evidence tendered revealed and was accepted by the Tribunal as a matter of fact, that segregation of the complainants had caused stress and anxiety to them and injurious effects on their health (at p. 64).

<sup>113</sup> Equal protection requirements in the 14th Amendment ('No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States, nor shall any State deprive any person of life, liberty or property, without due process of law; nor deny to any person, within its jurisdiction the equal protection of the laws') are met if all members of a certain class (for example, HIV-infected persons) are treated equally without any type of arbitrary classifications. Hence segregation was permissible because all HIV-infected persons were segregated (*Powell v Dep't of Corrections* 647 F. Supp 9968 (N.D. 1986). In *Cordero v Coughlin* 607 F Supp (S.D.N.Y. 1984) it was held that inmates have no constitutional right to freedom from segregation. If segregation was used to prevent transmission to inmates and staff it was recognised as a legitimate institutional objective. Eighth Amendment rights are not violated because prisoners with AIDS receive adequate food, clothing shelter, sanitation, medical care and personal safety. Further, First Amendment rights ('Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances') are not violated because the needs of the institution limit prisoners' rights to free expression and free association.

Australian *National HIV/AIDS Strategy* neither supported nor discouraged segregation but recognised that some form of separate facilities may need to be available to minimise the spread of HIV if requested by a prisoner or in his or her interests. It is easy to see how the duty of care that is owed to prisoners by prison authorities could lead to defensive practices being put in place by authorities. Arguably the best way to both protect a patient and discharge a duty of care may be to segregate a prisoner.<sup>115</sup> The Western Australian equal opportunity cases<sup>116</sup> reveal that prisoners should not by virtue of segregation be denied privileges that other non HIV-infected prisoners receive. For example, they should be able to undertake paid remuneration commensurate with their health abilities. In addition, these separate facilities should have special procedures, such as additional visits from counsellors.<sup>117</sup>

Prison legislation in all Australian States and Territories has provisions allowing for general segregation for the purpose of security or good order of the prison.<sup>118</sup> Hence, infected prisoners who spit or bite could be segregated on the same basis as any other prisoners would normally be when engaging in violent activities.

Although there are few specific provisions in Australian State or Territory<sup>119</sup> legislation for prisoners identified as HIV-infected to be physically separated from other prisoners, the early trend was towards segregation. For example, in 1988 several HIV-infected prisoners were being confined in the prison hospital at Pentridge Gaol in Victoria.<sup>120</sup> Prior to 1990 HIV-

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<sup>114</sup> at para. C(4) 'Prisoners should not be subjected to discriminatory practices relating to HIV infection or AIDS such as ... segregation or isolation, except when required for the prisoners own well-being.'

<sup>115</sup> This issue about the duty of care owed to prisoners to protect them from harm was considered under the section entitled 'Prisoners Rights' *supra*.

<sup>116</sup> discussed *supra*.

<sup>117</sup> *supra* note 63, para. 5.8.7.

<sup>118</sup> s. 39(1) *Corrective Services Act* (1988) (Qld.); s. 36(3)(4) *Corrective Services Act* (1982)(S.A.); reg. 33 *Prisons Regulations* (1985)(Tas.); reg. 53(1) *Corrections Regulations* (1988)(Vic.); s. 60 *Prisons (Correctional Services) Act* (1985)(N.T.); r. 9(3) *Remand Centres Regulations* (1976)(A.C.T.).

<sup>119</sup> except New South Wales, where reg. 20 of the *Prisons (Administration Regulations)* (1989) and *Prisons (General) Regulation* (1989) reg. 35 allows for separation of the prisoners suffering from 'any infectious or contagious disease' from other prisoners to prevent the spread of disease.

<sup>120</sup> 'Jika-Jika AIDS Unit Idea', *The Mercury*, February 6 1988.

infected prisoners were incarcerated in an isolation section in Sydney's Long Bay Prison known as the Malabar Assessment Unit (or the 'AIDS Unit' as it came to be known). In Tasmania, all HIV inmates were housed in the prison hospital. Section 43 of the *Prisons Act* (1981)(W.A.) and regulation 54(c) of the *Prisons Regulations* (1982)(W.A.), later known as Rule 3Q relating to separate confinement allows antibody positive prisoners to be medically isolated within the prison hospital and HIV positive prisoners were placed in the hospital in Fremantle maximum security prison until it ceased operation in 1991.<sup>121</sup> However, this segregation policy has continued at other Western Australian prisons.<sup>122</sup> Queensland and the Northern Territory also favoured segregation. In Tasmania, Queensland, Western Australia and the Northern Territory, where the numbers of infected prisoners are low, this segregation policy has continued.<sup>123</sup>

Confidentiality concerns stemming from segregation results in a breach of guideline 5.70 of the *Standard Guidelines for Corrections* in Australia, which reads:

Prisoners isolated for health reasons should be afforded all rights and privileges which are accorded to other prisoners so long as such rights and privileges do not jeopardise the health of others.

In 1991, a Western Australian prisoner was awarded compensation from the WA Equal Opportunities Tribunal on the basis that his segregation on grounds of HIV infection denied him the opportunity to undertake prison employment and to take advantage of counselling and recreational benefits.<sup>124</sup> The court held that the Director of Corrective Services was obliged under section 95 of the *Prisons Act* (1981)(W.A.) to allow the complainant 'an opportunity to earn remuneration and to take advantage of counselling facilities and recreational benefits, such as the minimum security activities.' The issue of segregation has been the source of a further successful application to the Tribunal in that State.<sup>125</sup>

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<sup>121</sup> *Report of Select Committee*, *supra* note 42, at p. 57.

<sup>122</sup> As confirmed in *A Complainant & Anor v The State of Western Australia* (*supra* note 53), at pp. 21-24.

<sup>123</sup> See Commonwealth Government, *State Stories*, *supra* note 70, at pp. 62-63 for N.T.; p. 66 for Qld.; at pp. 70-72 for Tas; at pp. 79-81 for W.A.

<sup>124</sup> *Hoddy v Executive Director Department of Community Services*, *supra* note 54.

## (ii) Integration

Integration involves the mixing of HIV-infected prisoners with the general healthy prison population rather than confining them in particular cells or prison hospitals. Integration has been considered by some prison authorities as a useful policy in dealing with AIDS. For example, as a result of mounting criticism about breaches of confidentiality, New South Wales have changed from segregation to integration.<sup>126</sup> Although Section 22 of the *Prisons Act* (1952)(N.S.W.) allows the separation of prisoners to 'prevent the contamination arising from the association of prisoners', there is now in place an active integration policy in New South Wales prisons following the release of the compulsory testing model in 1990.

In Victoria, a special unit for HIV-infected prisoners has been established in 'K' division at Pentridge. However this unit also houses non-infected persons who volunteer for the unit. Although it is a special unit it also has features of integration, given the presence of the healthy inmates. The officers who work in the unit volunteered to do so and both staff and prisoners believe the unit works well. Given that offenders convicted of a range of offences are grouped together under this scheme such an arrangement may prove difficult to maintain in the future.<sup>127</sup>

South Australia has always had an integrated policy. An 1988 amendment to the South Australian *Corrective Services Act* (1982) allows for the segregation of prisoners for a period of no more than 14 days in the interests of their safety and welfare and of other prisoners or if they are likely to injure or unduly harass another.<sup>128</sup> This provision could apply to an HIV-infected prisoner, although it is not HIV-specific.

The South Australian experience shows that harassment of HIV-infected prisoners has reduced since 1987 when the Department indicated its strong commitment to an integrated policy.<sup>129</sup> But the 1989 study at Yatala

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<sup>125</sup> *supra* note 53. In order to limit further applications to the Tribunal the Western Australian Parliament passed the *Equal Opportunity Act (Infectious Diseases) Regulations* (1994) which restrict the application of certain provisions of the Act to prisoners suffering from a disease. This exemption is specifically stated to be until January 31 1995 to enable the Prison authorities in that State to adapt their present policies which have been shown to be discriminatory.

<sup>126</sup> Yabsley, M., 'Government Prisons Policy' (1990) 136 *Civil Liberty*, 3-8, at p. 5.

<sup>127</sup> Harmsworth, *supra* note 91, at p. 129.

<sup>128</sup> s. 36. And see Commonwealth Government, *State Stories*, *supra* note 70, at pp. 27-28.

<sup>129</sup> Bloor, *supra* note 103, at p. 139.

Prison revealed that 66% of prisoners surveyed thought that HIV-infected prisoners should be isolated.<sup>130</sup>

Overall, segregation policies would not be detrimental to the infected prisoner provided it does not become another form of punishment. Dwyer suggests, based on his experience working within Long Bay Jail, that discontent, violent behaviour and attacks on prison officers are far more likely to occur in a segregated rather than an integrated situation.<sup>131</sup> There is no need for security type classifications on the basis of merely being HIV-infected. Some European countries have responded to this by having an integrated system and treating any HIV-related offence similar to other prison offences which may result in solitary confinement.<sup>132</sup> Integration can work with appropriate education of the general prison population. It is to this educational policy that attention must now turn.

## EDUCATION

The WHO 'consensus statement' urged that education was foremost in dealing with the AIDS crisis.<sup>133</sup> This is especially so since many prisoners are socially deprived persons with lower than average education<sup>134</sup> and hence may not have been effectively educated in the general community about the dangers of their high-risk practices. The *National HIV/AIDS Strategy* has stressed the need for specific education programmes to be available for new and existing prisoners and those about to be released, with staff and inmates involved in presenting HIV education programmes.<sup>135</sup> Prison officers are required to undergo educational programmes as part of their training.

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<sup>130</sup> Douglas, *supra* note 1, at p.62.

<sup>131</sup> Dwyer, *supra* note 4, at p. 113.

<sup>132</sup> Denmark, and The Netherlands, reported in Harding, *supra* note 14, and confirmed as still the position in 1990 by Directorate of Prison Medical Services, HM Prison Service Headquarters London, in 'AIDS/HIV: Statement of Current Prison Service Policy', Paper presented to HIV/AIDS and Prisons, 19-21 November 1990, *supra* note 4, Melbourne.

<sup>133</sup> para. C (2)(a).

<sup>134</sup> Conolly, L., and Potter, F., 'AIDS Education in Australian Prisons' (1990) 23 *Australian and New Zealand Journal of Criminology*, 158-164, at p. 162.

<sup>135</sup> *supra* note 63 paras. 5.8.2 and 5.8.3.

Education programmes in Australian prison policies vary in structure and regularity. Generally, they target two groups: staff and inmates.

#### (i) Training for Prison Officers

New South Wales has the most comprehensive training programmes available for prison officers. There are regular information sessions and trauma counselling available. The other States have various officer training schemes South Australia offers on-going voluntary education programmes. Resource kits are reportedly available in almost all prisons.<sup>136</sup>

A number of problems have been encountered with officer training programmes. There have been reports in New South Wales that officer training has been thwarted by Superintendents in prisons who are concerned about the financial resources and time commitments of staff. There is also evidence of considerable peer pressure in avoiding use of certain protective procedures.<sup>137</sup> For example, junior officers were labelled by Senior officers as 'sissies who should not be on the job'<sup>138</sup> when they used rubber gloves for cell searches and blood spills.

#### (ii) Prisoner Education

Prisoner education schemes include the provision of leaflets and voluntary education in Western Australia, the provision of education programmes for all prisoners within 4 weeks of entering the system in Tasmania, the education of prisoners prior to compulsory testing in Queensland, peer education programmes which also focus on Aboriginals and developmentally delayed prisoners in New South Wales, and education at reception, throughout and immediately prior to release in Victoria.<sup>139</sup> The Northern Territory correctional system has had no prisoner education

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<sup>136</sup> Liehne, P., and Williams, J., 'HIV/AIDS in Australian Prisons A Commonwealth Perspective', Paper Presented to HIV/AIDS and Prisons Conference, 19-21 November 1990, Melbourne, Table 2.

<sup>137</sup> Adamson, E. H., 'Prison AIDS Project Custodial Officer Education', Paper Presented to the HIV/AIDS and Prisons Conference, 19-21 November 1990, Melbourne, *supra* note 4, 211-220, at p. 213.

<sup>138</sup> Adamson, *Ibid*, at p. 213.

<sup>139</sup> Liehne, *supra* note 136, at Table 3.

campaigns since 1987 and in Queensland, there have been none since 1986.

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The effectiveness of Australian prison HIV education has not been studied well yet. But the Yatala study suggests that both prisoners and officers of that prison did not think that AIDS education had resulted in a substantial reduction in risky behaviour such as IV drug use. The study also revealed that educational programmes in 1989 were not getting the information across to prisoners.<sup>141</sup> A similar study in Western Australia reveals that the majority of prisoners and officers claimed they would like more information on AIDS.<sup>142</sup>

AIDS educational programmes must meet certain refinements. Use of small discussion groups with an external expert or doctor, then videos and films or movies, has been found to be 'a good way' to educate prisoners.<sup>143</sup> Further, an AIDS Education Evaluation Programme which began in New South Wales in 1987 and continued into late 1989 found that educational messages did not fit AIDS prison policy.<sup>144</sup> For example, in the general community people are encouraged to use condoms and not to share needles. To cover this, availability of condoms and needles has increased. In Australian prisons, condoms<sup>145</sup> and needles are not available, yet the AIDS educators teach prisoners to use condoms and clean needles if they have to share them. The policy and the education do not fit together.

Education is an important facet of HIV prevention which should be legislatively mandated. This would illustrate and confirm that is a priority public health objective that should apply both within and without prisons.

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<sup>140</sup> Norberry, J., and Chappell, D., 'AIDS in Prisons' (1989) 21 *Trends and Issues*, at p. 4.

<sup>141</sup> Douglas, *supra* note 1, at p. 63. The usefulness of AIDS Education in the Prison setting is evidenced by the programme conducted at Worcester Country House of Corrections in the United States, where there have been fewer episodes of violence and discrimination since the programme began (Norton, R., 'AIDS Education in United States Prisons: What Needs to be Done', *Report of the Third National AIDS Conference*, Canberra, Australian Government Publishing Service, 1988, at p. 621).

<sup>142</sup> Close, H., 'Perceptions of AIDS in Prisons: Relevance in Developing Educational Strategies', Paper presented to HIV/AIDS and Prisons Conference, 19-21 November 1990, Melbourne, *supra* note 4, 221-232, at 223.

<sup>143</sup> *Ibid*, at p. 227.

<sup>144</sup> Conolly and Potter, *supra* note 134, at p. 162.

<sup>145</sup> with the exception of the A.C.T. where condoms have been available since December 1992 under a pilot scheme (Anon, 'Condoms in ACT prisons' (1993) 4/1 *National HIV/AIDS Legal Link Newsletter*, 11).



## COUNSELLING

Counselling is seen by many experts as a useful AIDS policy in prisons. It normally involves the provision of support and information as to the social, medical, legal and ethical ramifications of infection with HIV. Counselling has been medically accepted as necessary prior to and after testing for HIV whatever mode of testing is implemented. Its necessity has been mandated under some State public health legislation that provides for testing of HIV.<sup>146</sup>

The need for pre-and post-test counselling in prisons irrespective of antibody status has been recommended in Queensland in the *Stir Report*.<sup>147</sup> The Commonwealth Government Discussion paper on *AIDS, A time to Care; A time to Act: a strategy for all Australians* stated that

Knowledge of whether or not one is infected may have some effect on the speed and direction of behaviour change, particularly if accompanied by professional pre-test and post-test counselling.<sup>148</sup>

The WHO 'consensus statement' endorses pre- and post-test counselling<sup>149</sup> However, the subsequent *National HIV/AIDS Strategy* can be criticised on this point for its vagueness. It simply states that counselling should be available in all cases where prisoners are tested for HIV<sup>150</sup> but does not detail what that counselling should entail and when it should be offered.

According to Norberry and Chappell, although a variety of counselling policies exist in Australian prisons, none are satisfactory.<sup>151</sup> Only South Australia and Western Australia have comprehensive policies in that there is pre- and post-test counselling irrespective of the outcome of the result. The majority of the States have post-test counselling only of antibody positive prisoners. Also, some pre-test counselling does not involve the use

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<sup>146</sup> detailed in chapter five, footnote 119.

<sup>147</sup> The *Stir Report*, *supra* note 100.

<sup>148</sup> *supra* note 66, at p. 71.

<sup>149</sup> para. C. 2. b.

<sup>150</sup> *supra* note 63, para. 5.8.6.

<sup>151</sup> *supra* note 12, at p. 4.

of professional counsellors and merely involves the prisoners reading pamphlets. <sup>152</sup> In 1993 it was specifically stated by the Commonwealth Government that it is unclear to what extent lip service is paid to counselling requirements in prison administration. <sup>153</sup>

### CONFIDENTIALITY

There have been developments in recent years elevating the protection of confidentiality and privacy of individuals to legal rights. The duty of confidence in a doctor and patient relationship is said to evolve from the very nature of the matters being disclosed. <sup>154</sup> Breach of confidence is a recognised action in contract, and in negligence if the failure to exercise due care leads to injury, and also in equity. <sup>155</sup> As prisoners do not lose all their civil rights upon incarceration, the duty of confidence is, in general terms, owed to prisoners as well as the community. However, as a general principle applicable to both the public and prisoners, if confidentiality is breached by a doctor in order to prevent harm occurring to a third party or the community then the breach will be regarded as legitimate. <sup>156</sup> However, in non-prison cases concerning breaches of confidentiality relating to HIV status it has been held that it is in the public interest that HIV status not be disclosed in favour of encouraging persons to prevent for voluntary testing. <sup>157</sup> Since

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<sup>152</sup> Liehne and Williams, *supra* note 136, at p. 10.

<sup>153</sup> Commonwealth of Australia, State Stories, *supra* note 70, at p. 65.

<sup>154</sup> *W v Edgell* [1990] 2 WLR 471; *Duncan v Medical Practitioners Disciplinary Committee* (1958) 1 NZLR 513.

<sup>155</sup> *Furniss v Fitchett* (1958) NZLR 396; *W v Edgell*. *Ibid*, *Argyle v Argyle* (1967) Ch 302. North, P. M., 'Breach of Confidence, Is there a New Tort?' (1972) 12 *Journal of Society of Public Teachers of Law*, 149 and Ricketson, S., 'Confidential Information - a New Proprietary Interest?' (1978) 11 *Monash University Law Review*, 289, at p. 296.

<sup>156</sup> *W v Edgell*, *supra* note 154. Here the trial judge stated that the duty of confidence owed to a patient in the position of the mental health prisoner in that case, was less extensive than the duty that would be owed by psychiatrists to ordinary members of the public. This point was not addressed on appeal. The present writer believes that the majority decision in the Court of Appeal which upheld the doctors action of breaching confidentiality is unsound because the court based its decision on the ground that the public interest in being protected from violence weighed more heavily than the prisoner's right to confidence. As the prisoner was not likely to be released in the near future and there was no transfer application or appeal being lodged there was no chance that he was to become a threat to the public. See also chapter six, pp. 267-272.

<sup>157</sup> *X v Y and Ors* [1988] 2 All ER 647.

testing is compulsory in the majority of Australian prisons it is unlikely that the same public interest exception would apply. However, the importance of confidentiality as part of a compulsory testing scheme has been discussed earlier in this chapter.

Public health statutes contain provisions directly contradictory of the maintenance of privacy of individuals. For example, there are responsibilities placed on doctors and, in some instances, on other persons to notify public health authorities of cases of communicable diseases, including AIDS.<sup>158</sup> Not all public health legislation protects against the unauthorised release of HIV-specific information. The advent of the 'AIDS crisis' has seen amendments made to legislation only in South Australia, New South Wales, Queensland and Victoria to cover this deficiency.<sup>159</sup> Such provisions have been regarded as legitimate exceptions to the rules regarding confidentiality.

Although a number of prison statutes<sup>160</sup> contain provisions that aim to prevent the release of confidential information they do not address HIV infection specifically. Only the New South Wales and Tasmanian legislation satisfies this requirement.<sup>161</sup> It is unclear often what the role of the doctor is with respect to information regarding the HIV status of a prisoner under his or her care. It must be recognised that a prison doctor has functions that differ from a doctor outside the prison. Not only does the doctor undertake to provide for the care of sick persons but there are tasks to be performed which support the prison system. For example, a prison doctor will often have to provide advice as to what type of institution the prisoner is physically and mentally suited and whether the prisoner is fit for work. Further, because of the unique characteristics of the prison doctor's clientele, information may come to his or her knowledge which is relevant to the security of the prison. Such institutional considerations place different obligations on the prison doctor unlike his or her counterpart working outside the prison. Balanced with this is the fact that HIV status is confidential information and the release of such information could result in dire consequences for a prisoner, such as discrimination in both employment and accommodation and the possibility of

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<sup>158</sup> The statutes are set out in chapter five, footnote 11.

<sup>159</sup> The terms of the legislation is covered in chapter five, pp. 196-200.

<sup>160</sup> s. 20(5), 30 *Corrections Act* (1986)(Vic.); s. 50(5)(a) *Corrective Services Act* (1988)(Qld.) and s. 61 *Corrective Services (Administration) Act* (1988)(Qld.); s. 39(c) and ss 98 and 102 *Prisons Act* (1981)(W.A.).

<sup>161</sup> reg 34A *Prisons (Administration) Regulation* (1989)(N.S.W.); s.19 *HIV/AIDS Preventative Measures Act* (1993).

violence for a prisoner, within the system and also upon release. Any legislation that authorises testing must set down some strategy for the use that will be made of the test results. In addition, the legislation must detail who has a right to be advised of the antibody status of the prisoner.

Stringent guidelines or legislative provisions need to be enacted focusing on who within the prison system should have access to information about the antibody status of a prisoner. This aspect warrants examination by considering the personnel in the prison environment.

#### (i) Medical Personnel

In all Australian Prisons the policy is that the Medical Superintendent is informed of the antibody status of the prisoner. Public health legislation casts a duty on medical practitioners to notify cases of AIDS and in some instances HIV infection to public health departments.<sup>162</sup> Prison medical officers would fall within that general inclusion and would have to notify Health Departments when cases arose. This fact alone would justify medical staff being apprised of the HIV antibody status of a prisoner.

#### (ii) Prison Administrators

In nearly all Australian prisons, both Prison Superintendents and Department heads are provided information about the antibody status of particular prisoners.<sup>163</sup> It is doubtful that prison administrators 'need to know' the identity of an HIV-infected prisoner if the reason is related merely to the implementation of various strategies. All they would need to know is the number of infected persons and their security classification within the prison.

#### (iii) Prison Officers

Similarly, the instances in which a prison officer needs to have information about the HIV antibody status of a prisoner are limited. Heilpern and Egger reported in 1989 that some prisons notify all staff.<sup>164</sup> There are only two justifications for releasing such information to prison officers. The

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<sup>162</sup> see statutes set out in chapter five, footnote 11.

<sup>163</sup> Heilpern and Egger, *supra* note 6, at p. 72.

<sup>164</sup> for example, Northern Territory.

first is where an officer will come into contact with the specific prisoner and would need to know the prisoner's antibody status in order to provide specific care for the prisoner. In those prisons where officers are assigned to special units, then, unless they are rotated, there is no reason that those officers who do not have any day-to-day business in that section should be notified of the antibody status of the prisoners. Uniform universal precautions set in place would be sufficient protection for these officers. The other justification is where a prisoner is aggressive to staff or engages in behaviour likely to place other prisoners at risk and staff need to know the prisoner's HIV status in order to take precautions to protect themselves from transmission.<sup>165</sup> However, once this information is provided to an officer, if he or she fails to prevent an infected person engaging in behaviour that he or she knew or should have known would occur then that officer may be liable if that other person becomes infected. The officer may be said to have breached his or her duty of care to the other prisoner.

It might be useful for Australian prison authorities to consider placing infected persons under a viral infectivity restriction order which would indicate to staff only that the prisoner had an infection. Such an order could also apply to other diseases. In England, where this practice is adopted restriction orders also apply to Hepatitis B carriers.<sup>166</sup>

#### (iv) Partners of Infected Prisoners

The question whether the partner of an infected prisoner needs to have access to his or her antibody status raises questions pertaining to the duty to warn third parties. If a prison doctor revealed such information it would be outside the notification requirements set down by statute. Also, a doctor would breach his or her obligation of confidence to his or her patient. Although there has been no chance for Australian courts to consider whether there would be a duty to warn third parties of the infected status of a person, US courts have considered it on a number of non-AIDS related occasions.

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<sup>165</sup> Heilpern and Egger, *supra* note 6, at p. 72.

<sup>166</sup> Directorate of Prison Medical Services, London, at p. 5. However the practice has been highly criticised in England as the source of breaches of confidentiality and discrimination within the system (Padel, U., 'HIV and prisoners' rights' (1990) 12 *Liverpool Law Review*, 55-68 and in the Wolff Report, *Prison Disturbances: Report of Inquiry by the Rt Hon Lord Justice Woolf (Parts 1 and II) and His Honour Judge Stephen Tumin (Part II)*, Home Office, London, Cm 1456, 1991).

The issue, however, mainly raises questions of tort liability. In *Tarasoff v Regents of the University of California*<sup>167</sup>, a non-HIV case, a psychotherapist was held to have a duty to effectively warn a woman that his patient was contemplating killing her. Whether this case may persuade courts in Australia and then be applied to informing partners of HIV-infected prisoners is questionable. A later US case concerning hepatitis B has limited the Tarasoff principle to situations where, even if the risk of infection to the public is foreseeable, the doctor's duty to warn a third party arises from a special relationship between the doctor and the third party.<sup>168</sup>

In Australia unless there is a clear and imminent risk to a third party, it is likely that the duty to maintain confidentiality will override the duty to warn third parties.<sup>169</sup> If, for example, conjugal visits were permitted within the prisons then there may be a duty to warn partners of infected prisoners. Some prisons have taken their own affirmative action. For example, in South Australia home detention or day leave will be declined where the prisoner objects to a third party who is at risk of being infected being advised of his or her antibody status.<sup>170</sup> Unless there is clear evidence that the prisoner may act in a manner placing the partner at risk of transmission of HIV infection this policy of South Australian prisons seems unjustified. In the absence of any clear guiding policy the present writer believes that policy makers need to decide whether the process of notification of third parties on behalf of prison doctors and other administrators should be discretionary or made mandatory. Although there is some logic in the view that 'the objective of medical confidentiality is perverted if it is used to facilitate the intentional transmission of disease'<sup>171</sup> there is a danger that if notification becomes mandatory then the doctor-patient relationship will be undermined. It may be sound policy to enlist the assistance of public health department personnel to try to convince prisoners to notify partners. As it is a requirement in Australia for all doctors including prison doctors to notify health departments of known cases of HIV

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<sup>167</sup> 131 Cal. Rptr. 14, 551 P.2d 340 (1976).

<sup>168</sup> *Gammill v United States* (1984) 727 F2d 950 (10th Cir.).

<sup>169</sup> In fact this question has been raised by Neave, M., 'AIDS, Confidentiality and the Duty to Warn' (1987) *University of Tasmania Law Review*, 1 -27. Neave suggests that *Tarasoff* will be unlikely to be followed because Australian courts are more conservative about extending the duty of care (at p. 26).

<sup>170</sup> Bloor, *supra* note 103, at p. 136.

<sup>171</sup> Glenn, H. P., Gilmore, N., Somerville, M., Moriseppe, Y. M., *HIV Infection, AIDS and Privacy*, Montreal, McGill Centre for Medicine, Ethics and Law, 1990, Working paper.

infection then prison officers may place the responsibility for persuading prisoners to notify partners at the hands of public health department personnel who may have been trained in partner notification skills.<sup>172</sup> This may be a preferred solution as many prison doctors may not have the time to undertake this role because the time involved may be viewed as prohibitive. Until information is available that would confirm that non-consensual notification to third parties placed at risk could discourage individuals from seeking care or from speaking candidly to their doctors, policy will have to be made in the face of uncertainty.

#### (v) Probation or Parole Agencies

As with prison administrators and prison officers there should be limits on parole or probation agencies having access to the HIV status of particular prisoners. Such agencies would only need to be advised of the antibody status of a prisoner if a prisoner is suffering from some debilitating condition of HIV infection and this factor may affect where a probation officer will place that prisoner on a work release programme. A prisoner's status should not be used to determine eligibility for work release and parole unless it is with that prisoner's consent. This is because in most cases a prisoner's HIV status would have no rational relationship to the offence for which he or she was convicted nor to any rehabilitation for that offence. However, it is unlikely that prisoners could invoke the equal opportunities legislation if they were denied parole placement because of the fact that the prisoner refused to consent to his or her status being disclosed. This is because the equal opportunities legislation requires discrimination in terms of the provision of a service and parole does not fit within this category. In addition, parole is not an entitlement but is discretionary.

Overall, it is suggested that notwithstanding that the duty of confidentiality is subject to so many exceptions that as a concept it is almost abandoned, the promise of confidentiality in a prison environment may be essential for a prisoner to come forward for testing. It may be argued that given that compulsory testing is mandated in nearly all Australian prisons that this proposition is without justification. However, the need for confidentiality is not lessened where compulsory testing is the norm. It is arguably more important because the right to choose to take the test has been taken away from subjects and the only way this can be justified is if procedural

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<sup>172</sup> This view is supported by Neave, *supra* note 169 at p. 22.

safeguards have been clearly set in place. In addition, there are other circumstances that are not covered by existing legislation or policy. For example, it could be questioned whether police should be notified of the HIV status of a prisoner who flees the jurisdiction while on probation or parole. Notwithstanding the fact that breaches of confidentiality might be legitimated in some circumstances and protected under the law, Australian prison authorities would be disregarding their responsibilities under the WHO guidelines and the *National HIV/AIDS Strategy* if provisions for protecting confidentiality are not put in place and adhered to.

### MEDICAL CARE

The WHO 'consensus statement' stresses that medical care is to be of the same quality for prisoners as for AIDS patients in the general community.<sup>173</sup> The *National HIV/AIDS Strategy* specifies that HIV positive prisoners should have the best practicable medical services, including access to counselling, treatment and nutrition appropriate for people with HIV.<sup>174</sup> There have been few studies of the adequacy of medical care available to prisoners in Australian prison systems. Arguably if the person is detained for punishment not as punishment then a prisoner has the right to care as good in the prison hospital as on the outside. It has often been argued that medical care is sub-standard within prison hospitals or that inadequate treatments are available.<sup>175</sup> The failure to treat adequately in prisons may be directly relevant to the tension between the aims of retribution and rehabilitation in the criminal justice system as a whole.

One issue that may arise in the prison is whether there is a duty on the part of medical staff to treat infected persons. It is recognised under general legal principles that a doctor only has a duty to treat in emergency situations.<sup>176</sup> Kennedy and Grubb suggest that an undertaking will not be

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<sup>173</sup> C 2 (c).

<sup>174</sup> *supra* note 63, para. 5.8.8.

<sup>175</sup> see the Select Committee Inquiry, *supra* note 42, at p. 57.

<sup>176</sup> This is confirmed by the criminal law. For example, in the Western Australian *Criminal Code* there are two duties: the duty to provide the necessities of life (s. 262) and the duty to do acts the omission to do which may be dangerous to human life or health apply to the provision of medical treatment (s. 267). These provisions set up a duty to treat in emergency situations where the patient is deprived of the capacity to consent. Where a competent person does not consent to treatment a doctor does not have a duty to treat because any



held to exist in law merely because of the coincidence of an emergency and a doctor nearby.<sup>177</sup> The law, they suggest 'does not impose an obligation upon a doctor to act as a good samaritan'.<sup>178</sup> However, they later concede that if a person came to a hospital and collapsed next to an off duty doctor 'arguably the law would determine that the doctor was not entitled to ignore the call for help'.<sup>179</sup> Similarly, if a patient came to a hospital expecting treatment the common law would support the argument that the patient has a claim to be treated and with due care and skill.<sup>180</sup>

The matter of refusing treatment to a class of persons has been covered by legislation in Australia. In 1989, the Victorian government amended section 4(aa) and (f) of the *Equal Opportunity Act* (1984) (Vic.) following a move to impose a ban on HIV-infected patients by the Freemason's hospital in East Melbourne. This rendered illegal any discrimination against anyone based on infection or perceived infection with a disease causing organism. In effect, this legislation prohibits Victorian hospitals from refusing to treat HIV-infected persons. Anti-discrimination legislation has been passed in nearly all States and Territories which applies to discrimination on the grounds of AIDS. However, the legislation which would be raised to prevent discrimination in medical treatment due to 'asymptomatic' HIV infection status as opposed to 'symptomatic' HIV status has been passed in only two States and the Territories.<sup>181</sup> The legislation

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treatment would technically be amount to an assault. Similar provisions exist in the Queensland and Tasmanian Codes.

<sup>177</sup> Kennedy, I., and Grubb, R., *Medical Law: Text and Materials*, 2nd ed, London, Butterworths, 1994, 79-80.

<sup>178</sup> *Ibid*, at p. 79.

<sup>179</sup> *Ibid*, at p. 80.

<sup>180</sup> This was the essence of *Barnett v Chelsea and Kensington HMC* [1968] 1 All ER 1068.

<sup>181</sup> Although it must be recognised that not all states have in place such legislation. In fact, prior to 1991 only New South Wales (*Anti-Discrimination Act* (1977)), Victoria (*Equal Opportunity Act* (1984)), South Australia (*Equal Opportunity Act* (1984)) and Western Australia (*Equal Opportunity Act* (1984)) allow people with AIDS to complain of discrimination on the grounds of physical impairment. Such a provision will not cover an asymptomatic HIV-infected person (with the exception of Western Australia where the EOT in the 1991 decision in *Hoddy v Executive Director Department of Corrective Services* (*supra* note 54) has extended the term 'impairment' in the legislation to cover HIV infection that has not progressed to the symptomatic stages, but see new legislation *supra* note 125, which exempts prisoners from that provision until 31.1.95). An HIV-infected person who was refused entry to a hospital on the grounds of his antibody status received an out-of-court settlement in New South Wales following a complaint to the Equal Opportunity Commission (Patterson, D., 'Legal Issues: Refusal of treatment - complaint settled' (1991) *National AIDS Bulletin*, May, 26). Recognising this inconsistency, two States (Victoria and Queensland) and the Territories specifically provide that the term impairment includes the 'presence of

operates to confirm what might have been unclear prior to the advent of the AIDS epidemic, i.e. that a doctor has a duty to treat a person who may pose a health risk to the doctor. A 1992 report from the New South Wales Anti-Discrimination Board reveals that health providers have refused to treat patients.<sup>182</sup> The anti-discrimination legislation would apply to corrective services medical personnel.

Correctional services legislation imposes a duty to provide medical attendance and treatment at public expense.<sup>183</sup> The problem that is likely to arise in prisons is not so much a refusal to treat, but a refusal, or inability of prison medical teams, to supply all the various treatments available. Such treatments include pre- and post-test counselling, access to doctors experienced with HIV/AIDS, access to AZT (Azidothymidine) which may inhibit the spread of the disease, access to nutritional supplements and dietary advice, peer support services and hospitalisation.

The estimated cost of AZT per person per year is \$10,000 and it is unlikely that public prisons would bear those costs.<sup>184</sup> In the United States, the failure to supply AZT has been listed as part of prisoner claims of cruel and unusual punishment under the Eighth Amendment to the US Constitution.<sup>185</sup> While such a claim would not have the same standing in Australia because of the lack of constitutional rights on this ground, even if the cost is prohibitive any scheme involving administration of the drug in prisons must match that implemented in the general community. Given that any lack of choice of medical care for prisoners with HIV is unlikely to spawn successful litigation in this country - in the absence of a constitutional list of rights against

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organisms causing disease' (*Equal Opportunity Act* (1984)(Vic.); *Anti-Discrimination Act* (1991)(Qld.); *Discrimination Act* (1991)(A.C.T.); *Anti-Discrimination Act* (1992)(N.T.)). The Commonwealth has also legislated to cover this defect (*Disability Discrimination Act* (1992)(Cth)).

<sup>182</sup> New South Wales Anti-Discrimination Board, *Discrimination - The Other Epidemic*, Sydney, 1992, at p. 46.

<sup>183</sup> s. 16(1) of the New South Wales *Prisons Act* (1952) sets out this duty. In Victoria, s. 47 of the *Corrections Act* (1986) makes provision for 'reasonable medical care' to be provided to prisoners.

<sup>184</sup> US Prison studies report that, given the costs of treating AIDS patients range from \$40,000 to \$300,000 per year, strain will be placed on correctional agencies' budgets, in Note, 'AIDS Cases Found Concentrated in Few Prisons, Study Finds', *Criminal Justice Newsletter*, March 3 1986, p. 4-5. In Australia, the annual cost of AZT was reported to be \$10,000 in 1988 (Commonwealth of Australia, *supra* note 66, at p. 75).

<sup>185</sup> Easley, P. R., 'The AIDS Crisis in Prison: A Need for Change' (1990) 6 *Journal of Contemporary Health Law and Policy*, 221-238, at p. 237.

which violations can be measured, it is even more vital that the policies of treatment and care of prisoners are satisfactory.

There is presently little information available on how Australian prisons discharge their medical obligations with respect to HIV-infected prisoners. In Victoria, management of HIV-infected persons is in close association with Fairfield Hospital, the major AIDS hospital in Victoria. AZT is available through the hospital, with prisoners assessed for AZT in the same way as infected persons in the general community are.<sup>186</sup> The practice in other States is defective. For example, in New South Wales testing is carried out without trained counsellors. In Western Australia, the Parliamentary Select Committee on HIV/AIDS reported that the conditions for prisoners with HIV at Fremantle prison are 'inadequate and completely inappropriate'.<sup>187</sup> The situation in other State prisons systems has not been documented. As the complexity and array of symptoms associated with HIV infection and AIDS intensify, they challenge the prison systems capacity to deal with prisoners infected with the virus. On that ground it is questionable whether HIV-infected persons progressing to AIDS should be sentenced to a term of imprisonment or whether it might be a ground for early release. As the first point was covered in chapter six the latter issue will now be considered.

#### Parole Eligibility and the Effect of HIV Status

In the United States it has been argued that HIV-infected prisoners should be denied parole or probation because these pre-release or community based options cannot provide adequate medical care or minimise the risk of HIV transmission as effectively as prisons.<sup>188</sup> When assessing whether a prisoner is eligible for parole the question is whether a persons HIV status should alter sentences originally mandated. When determining eligibility it is reasonable that a person's medical condition and the propensity to which he or she might engage in violent or non-consensual acts which could transmit HIV to others would be relevant. It would be inappropriate for medical factors alone to warrant an extension of their imprisonment in the face of the presence of good behaviour periods. However, it would be difficult to ascertain whether such considerations have been paramount given that

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<sup>186</sup> Harmsworth, *supra* note 91, at p. 130.

<sup>187</sup> Report of the Select Committee, *supra* note 42, at p. 50.

<sup>188</sup> Vaid, *supra* note 48, at p. 232.

Parole Boards in Australian jurisdictions do not have to furnish reasons for denying parole to the prisoner. In addition, decisions cannot be appealed.<sup>189</sup>

In the United States, early release has been a option for some prisons.<sup>190</sup> However, in Australia, early release on the grounds of health cannot be considered other than on humanitarian grounds. It must be based on whether the individual has complied with the conditions of sentence, whether his or her release would jeopardise public safety from criminal behaviour (not from disease), and whether he or she is in need of continued guidance through community services.

## **6. ALTERNATIVE MEASURES FOR CONTROLLING THE SPREAD OF HIV WITHIN PRISONS**

If an HIV-infected person has been sentenced to a term of imprisonment because he or she has shown disregard for another then we must accept that this behavioural pattern could continue while in prison. As concluded in chapter six, where possible when courts are involved in sentencing HIV-infected persons whether or not HIV status is relevant to the crime committed, courts should where possible make use of alternatives to prison. Given that there are circumstances when this is not possible, or that persons may become infected while serving a term or imprisonment<sup>191</sup> resulting in a pool of HIV-infected persons in a prison population then prison authorities must consider the use of particular measures for controlling the incidence of HIV within prisons.

The WHO 'consensus statement' made reference to a number of other methods that could be implemented to control the spread of HIV within prisons. These included the distribution of condoms and needles to prisoners. These methods are not yet available in Australian prisons<sup>192</sup>, although their possible use has been debated. Prisoners do not have the same ability to protect themselves from participating in activities which may

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<sup>189</sup> For example, section 50 of the *Offenders Probation and Parole Act* (1963)(W.A.)(since 1990 known as the *Offenders Community Corrections Act* states that the rights to natural justice are denied.

<sup>190</sup> For example, in 1987 the New York State Division of Parole released fifty seriously ill HIV-infected prisoners (Sullivan, R., 'NY State paroles 50 men sick with AIDS', *New York Times*, July 3 1987, Section 1, p. 1).

<sup>191</sup> *supra* notes 39-40.

<sup>192</sup> with the exception of the Australian Capital Territory where a pilot condom scheme was set in place in 1993, *supra* note 145.

spread HIV as do persons outside the prison environment. As a result it is arguable that prisoners need access to harm reducing techniques more so than the general population. There is currently an inconsistency in the availability of condoms and syringes within prisons as opposed to the general population. As prison authorities owe a duty of care to protect prisoners from harm then it is arguable that the duty extends to the provision of HIV protective devices such as the provision of condoms, syringes and bleach.

### DISTRIBUTION OF CONDOMS

The WHO 'statement' suggested that careful consideration be given to making condoms available in the interests of disease prevention. The *National HIV/AIDS Strategy* <sup>193</sup> advocated the availability of condoms to prisoners, and not just as part as a pre-release package given to prisoners on their discharge, as is the case, for example, in Victoria. <sup>194</sup> From the late 1980s commentators have expressed support for the introduction of this measure. <sup>195</sup> However, in 1994 condoms are available in only one Australian prison jurisdiction. <sup>196</sup> Despite this, governmental working parties continue to recommend the introduction of this measure. <sup>197</sup>

Although condoms are not 100% effective in preventing transmission of HIV, there is no doubt that they can significantly reduce the risk of transmission when used correctly. <sup>198</sup> In the prison environment this would minimise the transmission of HIV through sexual activity.

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<sup>193</sup> *supra* note 63, para. 5.8.4.

<sup>194</sup> Harmsworth, *supra* note 91 at pp. 129-130. Harmsworth does not suggest any change to this model.

<sup>195</sup> Dwyer, *supra* note 4, at p. 112, Stir Report, *supra* note 100, at p. 21, Kirby, *supra* note 33, at p. 14, Heilpern and Egger, *supra* note 6, at p. 88, Gostin, L., 'Public Health Strategies for Confronting AIDS', *JAMA*, 1989, 261:1621-1630 at p. 1626. In 1990, more than 100 experts at the HIV/AIDS and Prisons Conference held in Melbourne reportedly called for condoms and needles to be made available on a trial basis (AFAO, 'Experts call for needle and condom trials in prisons' (1990) *National AIDS Bulletin*, December/January, 3).

<sup>196</sup> Australian Capital Territory, *supra* note 145.

<sup>197</sup> As clearly set out in New South Wales Ministerial Review HIV/AIDS Legal Working Party, *The Courage of our Convictions - HIV/AIDS: The National Strategy and the Laws of New South Wales*, Sydney, New South Wales Government Printer, 1993.

<sup>198</sup> Their effectiveness has been acclaimed in a number of studies: Rietmeijer, C., Drebs, J., Feorino, P., and Judson, F., 'Condoms as Physical and Chemical Barriers Against Human Immunodeficiency Virus', *JAMA*, 1988, 259:1851-1853. Roumeliotou, A., Papautsakakis, G., Kallinikos, G., and Papaevangelou, G., 'Effectiveness of Condom Use in Preventing HIV Infection in Prostitutes', *Lancet*, 1988, 1:1249.

There are major impediments to the introduction of condoms within prison systems. First, there has been resistance from prison officers who believe that condoms will be used to conceal contraband goods in body cavities.<sup>199</sup> Second, homosexuality is still a crime in Tasmania and is illegal in the prison systems of South Australia, Northern Territory, Queensland and Tasmania.<sup>200</sup> It would be contradictory for prisons to issue condoms in those circumstances as the provision of condoms in prisons would be seen as condoning homosexuality.

The failure to distribute condoms does not offend the 'consensus statement'. The statement only urges that 'careful consideration be given to making condoms available in the interests of disease prevention'. If a condom policy were to be established, those States that currently criminalise consenting sexual activity, or indeed any sexual activity, would need to amend the relevant legislative provisions. The Tasmanian Upper House is still strongly resisting the decriminalisation of consensual homosexual activity. Further, given that generally Australian legislation still renders homosexual activity taking place in public an offence, and that prisons might be considered public places, that element must also be amended. This is necessary for any educational policy encouraging use of condoms for safe sexual practices to have any impetus.

It is arguable that prison authorities have a duty to enable sexual activities to be practised safely by the use of condoms. It is worthwhile to note that in the Yatala study, 42% of prisoners thought that if condoms were available anal sex would increase and 63% thought most prisoners would not bother to use them if they were available. However, 80% of prisoners said consenting partners would use condoms.<sup>201</sup> In light of this information, is not surprising that the South Australian HIV/AIDS Strategy recommends that condoms be available to all prisoners.<sup>202</sup> However because sexual conduct between prisoners is illegal under the *Corrective Services Act* in that State, the provision of condoms would be inconsistent with legislation.

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<sup>199</sup> Kirby, *supra* note 33, at p. 14, and Lake, S., *AIDS in Prison*, Unpublished Manuscript, Sydney, School of Law, University of New South Wales, 1990.

<sup>200</sup> Reg. 20 *Corrective Services Act Regulations* (1985)(S.A.), s. 122-123 of the *Criminal Code* (1924)(Tas.) will apply to prisoners. Section 93 of the *Corrective Services Act* (1988)(Qld.) penalises assault and could conceivably cover sexual assaults.

<sup>201</sup> Gaughwin, *supra* note 1, at p. 62.

<sup>202</sup> See Commonwealth of Australia, *State Stories*, *supra* note 70, at pp. 27-28.

As noted earlier in this chapter, it is a well established principle of tort law that correctional authorities owe a duty of care to persons under their care and control and a breach of this duty gives rise to a claim in negligence.<sup>203</sup> This duty has been held to extend to the taking of reasonable care to prevent one prisoner harming another.<sup>204</sup> If one prisoner infects another with HIV while in prison then as this is a demonstrable harm prison authorities may be held responsible in negligence.

This is the substance of a 1993 action commenced against the State of New South Wales by prisoners to restrain the government of that State from refusing to permit prisoners to possess and use condoms in prisons.<sup>205</sup> The two grounds of relief are a claim for an injunction to restrain the Crown from an alleged ongoing breach of its duty of care in preventing the distribution of condoms in prison. Second, a declaration that the Commissioner of Corrective Service's decision to withhold condoms is so unreasonable that no reasonable person could have exercised the power and that it was exercised taking into account irrelevant considerations. The Crown argued that an injunction was not the appropriate remedy to prevent a duty of care and that there was no operational decision affecting a particular prisoner capable of attracting an administrative law review by the court. The Crown also asserts that a government policy is not justiciable. On this latter point the prisoners have argued that the decision to withhold condoms is a general operational decision affecting many prisoners and so it is a reviewable administration law decision. The decision has been reserved. If the prisoners are successful then similar actions may be commenced in other jurisdictions.

If condom distribution will not be permitted then other methods must be found to limit or prevent sexual transmission in prisons. Such methods include increasing conjugal visits so as to reduce homosexual activity, the provision of single-cell accommodation, the close supervision or isolation of sexual predators and educational campaigns that advocate 'no sexual practices' in prisons. Such campaigns seem ludicrous when one

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<sup>203</sup> *Ellis v Home Office* [1953] 2 All ER 149, at p. 154, *Howard v Jarvis* (1958) 98 CLR 177 and *L v Commonwealth* (1977) 10 ALR 269.

<sup>204</sup> In *Dixon v The State of Western Australia* [1974] WAR 69 Western Australian prison authorities were found negligent for failing to prevent a prisoner assaulting another where he had a history of violent behaviour and authorities failed to isolate him. In the case of *L v Commonwealth* the Northern Territory authorities were found liable for failing to prevent a sexual assault where a prisoner was placed in a cell with two others who were prone to violence: (1977) 10 ALR 269.

<sup>205</sup> *John Doe, Richard Roe and Others v State of New South Wales*, reported in 'Prisoners sue for the right to condoms' (1994) 5(1) *National HIV/AIDS Legal Link*, 1, 11.

considers that prisoners will re-enter the community and as such will not be educated as to the preventative practices existing in the general community aimed at combating the spread of HIV.

### DISTRIBUTION OF SYRINGES

Needle-exchange programmes have been widely promoted as a strategy to curb the spread of HIV among IV drug users. Australia has a well-developed policy of needle-exchange programmes in the general community in every State or Territory.<sup>206</sup> Legislation has also been amended to decriminalise possession of syringes and their supply by pharmacists.<sup>207</sup> The success of needle-exchanges in reducing the spread of the virus has not yet been tested, although there are some studies pointing to a decline in needle-sharing<sup>208</sup> but not in drug use overall.

The WHO 'consensus statement' suggests that governments,

may wish to review their penal admission policies particularly where drug abusers are concerned in the light of the AIDS epidemic and its impact on prisons.<sup>209</sup>

This supports the supply of needles within prisons. The Yatala prison survey suggested that '93% of prisoners agreed that if clean needles were available the risk of transmission of HIV would be reduced', hence indicating that they would be used. However, few commentators who support the distribution of condoms favour a distribution of needles.<sup>210</sup> Instead it has been

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<sup>206</sup> Shipway, S., 'Outlets for needle and syringe distribution and exchange in Australia' *National AIDS Bulletin*, July 1989. The Tasmanian system was legalised with the proclamation of the *HIV/AIDS Preventative Measures Act* (1993) and the Western Australian exchanges with the proclamation of the *Poisons Act Amendment Act* (1992) in 1994.

<sup>207</sup> The various State and Territory policies are detailed in Cuatt, L., *Tasmanian Pharmacists' attitudes and practices regarding the sale of needles and syringes to intravenous drug users*, Tasmanian AIDS Council, Hobart, February 1989, at pp. 7-10.

<sup>208</sup> For example, in England, a central London study shows over a one year period return rates (of needles) improved and needle-sharing declined: Hart, G., 'Needle exchange in central London: one year follow-up', University College, London, 1989.

<sup>209</sup> Section (G). In 1994 a pilot needle-exchange programme commenced in a prison in Switzerland. The results of this programme are not yet available (reported in 'Prisoners sue for the right to condoms', *supra* note 203, at p. 12.

<sup>210</sup> Gostin, *supra* note 193, at p. 1626 does not specifically endorse it. Neither does Harding, *supra* note 14, at p. 1262 nor the Stir Report, *supra* note 100 at p. 22. Yet Kirby does, in qualified terms, *supra* note 33, at p. 15.



suggested that active steps be taken to prevent illicit introduction of needles in prison and the prisoners be given information about use of dirty injection material.<sup>211</sup> In 1992 active steps were taken in New South Wales to prohibit the introduction or supply of syringes. The *Prisons (Syringe Prohibition) Amendment* (1991) was a political move to calm prison officers in the wake of the Long Bay Jail prison stabbing incident. Section 37A prohibits any form of needle equipment from being introduced into the prison or supplied to a prisoner. However the legislation is drafted in terms which would allow the provision of needles should such a scheme become acceptable in the future.

It is not difficult to see why needle distribution within prisons is resisted in Australia. The policy is clearly controversial when it is considered that drug users are incarcerated for drug-related offences. A needle-exchange policy within a prison would be a contradiction in terms. If needles will not be made available, then the argument that drug users should not be incarcerated for drug-related crimes becomes more persuasive. If needles will not be provided, the provision of bleach for cleaning syringes may be more acceptable. As sharing is part of the culture of IV drug use, needle-sharing may be hard to eradicate indefinitely in the prison environment. Even if prisoners will not discontinue sharing, they may be more likely to use bleach if it is available. Victoria and New South Wales are currently the only States where bleach is reportedly available to prisoners.<sup>212</sup>

There are other methods which may be adopted to curb the spread of HIV within prisons which were not covered in the WHO 'consensus statement' or the *National HIV/AIDS Strategy*. The usefulness of these in combating HIV will be examined briefly.

#### PROVISION OF SINGLE-CELL ACCOMMODATION

In Australian States and Territories there is a move towards single-cell accommodation. This is already the case in Tasmania, South Australia, Queensland and the Australian Capital Territory.<sup>213</sup> However,

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<sup>211</sup> *supra* note 63, at para. 5.8.5.

<sup>212</sup> See Commonwealth of Australia, *State Stories*, *supra* note 70, at p. 77. In New South Wales though bleach is available specifically to clean cells (Bloom, C., 'Bleach to be more accessible in gaols' (1994) 5/2 *HIV/AIDS Legal Link Newsletter* 13).

<sup>213</sup> Behrens-Peters, O., 'HIV Education Strategies Within Correctional Services - The South Australian Experience.' Paper presented to HIV/AIDS and Prisons, 19-21 November 1990, Melbourne, *supra* note 4, 199-210, at p. 200. All inmates in Tasmania and the Australian

communal showering facilities are the norm for a majority of prisoners in all States with the exception of South Australia where almost half the prison population have separate shower facilities.<sup>214</sup> The provision of single-cell accommodation would also decrease the likelihood of non-consensual risk practices taking place, for example, homosexual rapes, which, if allowed to occur, might result in transmission of the virus.

### PROVISION OF TREATMENT FACILITIES

In addition to the provision of specific medical support services for HIV-infected prisoners, other programmes need to be implemented which will also back up educational programmes on drug use.

Prisoners addicted to IV drug use must be given the assistance that would be available to them in the general community. This is especially incumbent on prison systems that are not able to prevent the infiltration of drugs into the system. It is recognised that relapse and recovery is the norm for drug users, and therefore it is mandatory that drug users be afforded some means to return to drug use without the deadly consequence of HIV infection.

The *National HIV/AIDS Strategy* urges that IV drug addicted prisoners have access to methadone programmes while on remand and during the course of their prison sentence.<sup>215</sup> Methadone is the only drug that has been found to successfully control drug addiction. The Liehne study reports that methadone programmes are available to varying degrees in Australian prisons.<sup>216</sup> Methadone should be available to those addicted to IV drug use but as part of a strategy designed to overcome their drug habits. Peer support could be used as a supplement to such a strategy. HIV-infected

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Capital Territory have single cells (See Commonwealth of Australia, *State Stories*, *supra* note 70, at pp. 70 and 57 respectively).

<sup>214</sup> Heilpern and Egger, *supra* note 6, at pp. 89-91.

<sup>215</sup> *supra* note 63, at para. 5.8.5.

<sup>216</sup> It is not available in the Northern Territory or Tasmania (Commonwealth of Australia, *State Stories*, *supra* note 70, at pp. 63 and 72 respectively) and is not available to long serving prisoners in Western Australia (Commonwealth of Australia, *State Stories*, *supra* note 70, at p. 45). It is available to remandees already on methadone on arrival in the Australian Capital Territory and available to HIV prisoners and heroin abusing prisoners to a maximum of 500 in New South Wales prisons (Liehne, *supra* note 136, Table 2, at p. 11). South Australia provides a limited programme to prisoners serving very short terms of imprisonment (who were on methadone prior to incarceration) to HIV-infected persons and pregnant prisoners who are drug dependent (Bloor, *supra* note 103, at p. 137). The position in New South Wales and South Australia is confirmed by Commonwealth of Australia, *State Stories*, *supra* note 70, at pp. 60 and 27-28. respectively.

persons should have access to such a programme as a priority in prisons where funds are limited.

## 7. CONCLUSION

The presence of infected persons and persons engaging in high-risk practices within prisons is well-documented and can no longer be ignored. Prison administrators can expect an increased burden of caring for and managing HIV-infected persons in the years to come.

As the advent of HIV has shown, there will be different views as to what is the appropriate manner of prison administration in a particular jurisdiction. Prisons usually reflect the prevailing philosophy but they have to respond to shifts in community values and changes in knowledge about various social issues including public health and punishment. The process of rehabilitation is assisted if prisoners are kept in touch with reality unless special circumstances of prison life preclude such an approach. Any policy must involve the balancing of conflicting demands and rights - the protection of prison officers and the wider community on the one hand, and the protection of prisoners and their rights on the other. Hence there needs to be a balance struck between the provision of a secure system of custody and the welfare of prisoners so that in due course they can return to the general community. In many jurisdictions the balance is not being struck in a manner which reflects a reasonable attempt to balance these competing interests. Current legislation still elevates the interests of the wider community health over the interests of HIV-infected prisoners. For example, compulsory testing legislation for prisons lacks provisions protecting confidentiality and fails to mandate both pre- and post-test counselling. Further, prison officers have through their unions had an influential hold over prison administration. They have either strongly supported measures which are not beneficial to HIV-infected prisoners such as segregation or have demanded legislatures to enact various prohibitions to ensure their own protection, such as the syringe prohibition and property confiscation legislation. These unions have been very influential in prison administration. Prison authorities have been concerned that if the union's required restrictive practices were not followed there may be problems for the management of prisons, in the form of strike action.<sup>217</sup>

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<sup>217</sup> As documented in *A Complainant & Anor v The State of Western Australia*, *supra* note 53, at p. 24

The refusal to supply condoms and needle cleaning equipment within Australian prisons shows that Australia still seems to be struggling with basic public policy issues relating to homosexuality, drug use and the HIV/AIDS epidemic which is a kind of primitive homophobia or narcophobia. A conflict is perceived between the urgent need to prevent the spread of HIV and demands to suppress drug use. The supply of both condoms and syringes need to be considered by prison administrators if the spread of HIV is to be curbed within prisons. Like testing these are not ends of their own but, as part of an educational package, could have formidable results. If prisoners are thought not to have justiciable rights they are rendered a relatively powerless group. It is therefore, incumbent on prison authorities or legislatures to develop legislation or policy which regulates testing and requires structures to be set in place which ensure that education, counselling, confidentiality and reasonable medical treatment are provided to prisoners.

The prison system as part of the criminal justice system provides an ideal vehicle for assessment of certain prevention programme strategies. Prison administrators have the power to adopt substantive prevention policies given the significant degree of legitimate control they have over prison population. They have a unique opportunity, which is unavailable to other community services, to combat the spread of HIV. They have the basis upon which to develop a uniform national prison policy, thereby ensuring the uniform treatment of prisoners across Australia.

## CHAPTER 8

### GENERAL CONCLUSION

Throughout this thesis HIV/AIDS has been referred to as an 'epidemic' or a 'crisis'. The Chinese ideogram for crisis comprises two parts, one denoting danger and the other denoting opportunity. In 1994 it is apparent that in Australia, the rate of HIV infection across high-risk groups has slowed. The danger appears to have abated. Despite this, figures denoting HIV infection and AIDS will continue to increase. Many of these cases were a predetermined facet of the early years of the epidemic in Australia and control measures introduced in the middle to late 1980s would have little impact on these cases. As a consequence of this fact and the unavailability of a cure, the presence of this disease will continue to be felt within the various arms of the Australian criminal justice system. The danger to life and health from HIV also provides a rare opportunity to reappraise existing practices in the public health sphere and the criminal justice system.

The introduction set out three main objectives to this thesis. The conclusions to be drawn from each of these will be considered separately.

The first objective was to consider 'how the politics of AIDS and of disease and social problems of the past (and present) directly or indirectly influence the manner in which governments, courts and legislatures have acted in response to AIDS' (at p. 5). Chapters four and five illustrated that the governments response in Australia and elsewhere to previous encounters with communicable diseases and most notably sexually transmitted diseases was not a commendable one. Chapter two considered the legal response to those practices which governments and writers prefer to label as 'social problems'. These practices include prostitution, homosexual conduct and drug use. Chapters two, four and five each illustrated that historically scapegoating and stereotyping has been the method adopted by governments, legislatures and police departments for controlling social problems. One might readily defend these past practices on the ground that they developed in an era which regarded the individual as responsible to society and in this respect had to bow to governmental authority. However, in chapter four examples were provided of early public health amendments relating to HIV/AIDS which were directed at certain members of society.

These mirrored the policy adopted during the two World Wars when prostitutes were singled out for government and public health administration. Evidence was provided in chapter five of discriminatory practices being applied in many Australian States and Territories to members of high-risk groups, particularly homosexual men. The increase in autonomy rights and the development of anti-discrimination law in the second half of the nineteenth century conflicts with these examples of governmental ill-considered action.

AIDS has become a political-legal, medico-moral crisis. This was inevitable given that the group that was primarily affected by this epidemic were an already maligned minority group which had a strong voice in the more populous States of Australia. The voice of the gay movement in Australia brought politics back into law. Their cohesiveness and forcefulness operated to expedite the usually slow pace of legislative reform in many areas where reform was needed. Indeed, politics has been the cornerstone of the response to HIV as might be expected in a liberal democratic country. However, the downside of politics needs to be considered as well.

Politics has been a feature behind the early attempts at HIV specific legislative enactments which were covered in chapter four. It was noted that defects in the legislation in terms of being either underinclusive or overinclusive would mar the application of such provisions in any serious case. These provisions represented 'knee-jerk' responses from elected officials who were deluded into thinking that the war on AIDS could be won by law alone. The desire to quell community cries for retribution of HIV-infected persons was counterproductive. It cannot be estimated to what extent these early amendments in New South Wales, in particular, drove HIV infected persons 'underground'. The attempt by governments to satisfy competing community demands is reflected in the Tasmanian *HIV/AIDS Preventative Measures Act* which on the one hand attempts to encourage at-risk groups to come forward for treatment and testing, but, on the other hand, declares that the promotion of homosexuality is illegal and so alienates the very group it is seeking to persuade.

Politics has also been witnessed in the confines of prison administration since the advent of the crisis. At the level of operation it has been marked by unionism. Examples were provided in chapter seven of the history and politics surrounding the enactment of the *Prisons (Syringe Prohibition) Act* in 1992 in New South Wales and the conditions in Western Australian prisons that led to the cases of discrimination being taken by prisoners to the Equal Opportunity Tribunal in that State between 1992-4.

Prison officers have debated whether to strike if condoms are brought into prisons or HIV infected persons are not segregated. The presence of AIDS has seen Heads of Corrective Services and governments face facts about the incidence of high-risk activities taking place in Australian prisons. Policies of condom and syringe distribution in prisons could not operate side-by-side with the penalty provisions for drug use and sexual intercourse on the outside. These issues for consideration within the prisons have brought to the forefront the need to reconsider areas of legal prohibition in the community.

Governments have a long-standing political history of avoiding issues such as how to control prostitution and drug use. This fact was debated in chapter two. Heroin use in particular has been frequently cited by academics and social historians alike as the result of deep rooted social-cultural problems. The matter of decriminalisation of drug use reared its head again in the context of HIV. One unsatisfactory feature of the AIDS debate to date is the fact that there is still very little forward movement or frank discussion by governments since the late 1980s about what to do about drug abuse in Australia. There is no doubt that a comprehensive attack on the use of illicit drugs cannot be successful without addressing the psychosocial and environmental conditions that produce substance abuse. Current policy makers have been particularly reluctant to address the environmental correlates of substance abuse, since that requires developing strategies to redress fundamental gender, racial, ethnic, and economic inequalities in our society. The present writer believes that studies need to be undertaken to determine the correlation if any between alcohol and substance abuse and engaging in sexual and needle-sharing behaviours that are high-risk for transmission of HIV/AIDS. In addition, if unemployment, homelessness and poverty are relevant factors then an increase in any of these will impact on the criminal justice system. If there is such a correlation then we must address drug abuse and consider the contribution that the institutions of criminal justice can make to controlling the problem of drug use in society apart from pure criminalisation strategies.

In summary, chapters two, four and five of this thesis have shown that the peculiar sociopolitical conditions of a country, its public health tradition, the role of differing conceptions of the claims of privacy, the legal and social status of homosexuality, prostitution and drug use and the level of organisation and sophistication of the gay community, have all contributed to shaping AIDS politics and prevention efforts.

The second objective of this thesis was to 'provide support for the view that the criminal law should have a limited role in preventing the spread of the epidemic' (at p. 5). In order to substantiate this view chapter two considered the aims of the criminal law and determined whether they were suited to a disease such as HIV. It was recognised that the question of using the criminal law to prosecute instances of transmission of HIV lead inevitably back to a consideration of social power relations and the political and paternalistic role of criminal law. In this context it was necessary to consider that 'harm minimisation' or the 'least restrictive intervention' have become metaphors for the way in which criminalisation is considered in the 1990s. In addition, we have entered an era of increased personal autonomy in both the sphere of criminal law and more particularly in public health law. However, chapters three, four, five and six of this thesis reveal that respect for individual autonomy can conflict with the purpose of preventing HIV transmission.

The anti-criminalisation or anti-prosecution regime in this thesis had three platforms. The first consisted of the theoretical and historical arguments which were used to criticise such laws because they misunderstand what the problem they are trying to solve is about. This is the claim of the anti-symbolist. The present writer does not see the purpose in placing provisions in statutes that are not really attempting to remedy a problem but are purely symbolic. There are instances of criminal provisions that have this purpose and there are a number of academic writers who believe that the criminal law should be used for this purpose in controlling AIDS. Fundamentally, criminal law provisions were not developed for and are inadequate to deal with transmission of disease. They reflect the fact that responsibility for curbing disease should not be a function of the criminal law. By contrast, the Tasmanian *HIV/AIDS Preventative Measures Act* (1993) illustrates that in the public health arena it is possible to draft provisions in an educative tone which will be more likely to gain the desired compliance.

The second platform involved a philosophical critique which offered principled objections to interference in an individuals life for reasons beyond the protection of innocent others. Chapter two rekindled the debate between the aims of the criminal law: the enforcement of morality against the prevention of harm to others. It was indicated in this thesis that historically people turn to the lawmaker to unravel and eradicate social problems. More particularly people expect that unruly, undesirable or immoral behaviour will or should be controlled by the criminal law.



The thesis concluded that the overriding aim of the criminal law should be the prevention of harm, not the enforcement of morality or paternalism. This theory is applicable not only to AIDS but any other social problem for which guidance is sought from the criminal law. The theory was derived in large part from an analysis of the failure of the criminalisation model for drug use. Prosecutions should not be mounted against persons who infect others during consensual sexual intercourse or needle-sharing episodes. The categorisation of perpetrator and victim is not easily established in this scenario in the absence of any deliberate attempt by one party to misrepresent his or her infected status. The only justification left for imposing criminal liability in those circumstances is for the purpose of enforcing morality. History reveals that the criminal law has failed to enforce morality in the past through criminalising homosexual conduct, prostitution and drug use. In addition, prosecutions based on symbolic or deterrence grounds are likely to be counterproductive to those already oppressed minority groups in society who are in need of care and counselling.

The third platform encompassed the practical arguments that we have better things on which to spend law enforcement dollars. Problems with enforcement, proof, the death of the accused and/or the victim and the presumption of innocence were canvassed in the context of AIDS. In the early years of the epidemic prosecutorial authorities were encouraged to attempt to apply traditional criminal laws to HIV/AIDS transmission. Many prosecutions under such provisions had to be dropped for the variety of reasons considered above.

Taking these three platforms together, in the present writer's view no new criminal law should be made unless it addresses a known problem of such gravity and/or frequency that the law is the best or most desirable solution; unless it is likely to achieve its objectives; unless its projected outcomes are likely to be better than those presently existing; and unless it is significantly free of the risk of abuse. HIV specific provisions in criminal law cannot be justified by the gravity of the problem. Admittedly, HIV is a problem in the community in terms of health care but it is not a feature of all criminal activity. The history of the police selectivity in the enforcement of crime which was identified in chapter two provide little assurance that such provisions would be used in a responsible way. The writer concedes that clear non-consensual wanton acts of aggression which create a risk of transmission of HIV do harm others and are deserving of punishment. In those instances current criminal law provisions will be applicable. Instead of

creating a myriad of offences policy makers would be wise to address problems that will arise with respect to those offences that would most likely be relevant. As set out in chapter three, it is the offences of assault and sexual assault that can be realistically considered in the context of HIV. Presently the law does not protect the party who consents to sexual intercourse where circumstances involve misrepresentations as to HIV status by the other party. There needs to be legislative direction on the need to obtain informed consent and what an informed consent entails in the criminal law.

As indicated in the introduction, the main aim within this second objective was to set out what should be the appropriate nexus for the criminal law *vis-a-vis* public health law. It was clear that guidance as to the proper nexus lay in the theme or overall strategy for control of HIV in Australia. That theme has been clearly identified through the *National HIV/AIDS Strategy* as one of 'prevention' rather than 'prohibition'. It was argued that public health law with its history of useful objectives such as contact tracing, partner notification, the provision of counselling was better suited to curb the spread of HIV where the theme of prevention was foremost. However, the one proviso placed on the application of public health to control of the spread of HIV in this thesis is that it was the 'new' public health that was in control. The concept of a 'new' public health warrants examination.

Public health legislation has always provided penalties for exposing others to the risk of infection and has in place measures for removing infected persons from the general population. Upon analysis of these provisions it was found that many had been developed in a very different era of infectious diseases and could not be realistically applied to a disease such as AIDS with a very long incubation period and no cure. It became clear that there was a need to amend archaic provisions which had been inherited from a time when the ideology that governments of a society had any responsibility to an individual was not accepted as a social principle.<sup>1</sup>

The 'new' public health embodied a recognition that a voluntarist consensus has informed public policy decisions. The strategy for AIDS prevention thus reflected the proposition that the defence of public health was not dependent upon the abrogation of civil liberties and privacy, but was, rather, dependent upon the protection of such liberal values. A

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<sup>1</sup> Cumpston, J. H. L., *The Health of the People*, Canberra, Roebuck Books, 1978, at p. 8.

failure to recognise the importance of such values would have the counterproductive consequence of 'driving the disease underground'.

The policy in public health is now more attuned to striking a balance between competing interests, that of the community to be protected from disease, and the right of the individual not to be unfairly oppressed. The analysis in this thesis has the capacity to satisfy some of the demands of both sides of the debate concerning the right of the State to interfere to protect the community health. It thereby represents a balance between two extremes. The thrust of this thesis allows the State to maintain an interest in disease control and set limits to the appropriate behaviour of individuals while preventing abuses of individual rights. In the past, although individual interests and community interests have been regarded as worthy of protection they have also been seen to be incompatible. But 1990s public health policy reveals that this need not be so.

Rather than focusing on detention and isolation, provisions need to carry educational overtones and encourage persons at risk of infection to come forward for voluntary testing and counselling. The more novel statutes such as the Tasmanian *HIV/AIDS Preventative Measures Act* (1993) are drafted with an educative tone. However, chapter five has revealed that there are still many public health statutes that provide broad powers for public health officials to detain persons suffering from communicable diseases. Such provisions need to clearly set down the behavioural options a person has before they will be detained. Provisions need to delineate the factors that will be relevant in issuing a public health order. If we wish to encourage behavioural change that is long-standing then coercive measures such as cease and desist orders are not appropriate. Behavioural changes have to be the consequence of personal autonomy in order to be effective. Some of the practices that have emerged over the past decade in response to AIDS should inform the practice of public health more generally. For example, the principle of requiring informed consent to for HIV testing ought to apply to all clinical tests to which competent adults may be subject. Although many of the changes referred to in this thesis were AIDS-motivated they were also long overdue.

The third objective was to consider if, and if so how, the criminal justice system can contribute to curbing the spread of HIV (at p. 5). The problem in the past with the system of criminal justice having a useful application to control of social problems has been the conflict between the retributive and rehabilitation models of justice. This is a prime reason for the

inadequacy of prison medical services for the treatment of HIV as evidenced in chapter seven. Chapter six of the thesis has established that the criminal justice system does have something to offer in curbing the spread of HIV. Bail conditions could be used to encourage the use of HIV preventative practices. In sentencing, the controversial issue of reducing the spread of HIV in prisons could be quelled by awarding non-custodial sentences or more usefully imposing rehabilitation and treatment on offenders, particularly, drug users. This is an important policy direction given the evidence provided in chapter seven which indicated that a significant proportion of persons imprisoned in Australia were IV drug using property offenders. The fact that there are significant numbers of IV drug users in prison and that few States offer drug treatment programmes such as methadone treatment in prisons, renders the provision of these services a high priority. Admittedly in the other arms of the criminal justice system such as the police, there is no place available for the provision of treatment but it could be developed and such a theme is not incompatible with criminal law. The criminal law provides many victim-based services and these where relevant, could be extended to the defendant.

The thesis has also identified areas within the system of criminal trial and procedure where the needs of the accused and his or her victim are largely unprovided for. For example, the resolution of the issue of HIV testing in the criminal process for either the victim's benefit or to allow police to obtain evidence to substantiate the charge against the accused needs legislative intervention. Any resolution at that level may operate as the guide for the proper administration of HIV testing in the general medical sphere where the matter is currently in a state of flux.

The *National HIV/AIDS Strategy* has been referred to throughout this thesis. Even though it is not legally binding, the Strategy in both its editions <sup>2</sup> has been regarded as the foremost guide in the area of HIV/AIDS and the law in Australia. The limits of legislation in disease-control were recognised as early as 1907 when the Tasmanian Public Health Commissioner, Elkington stated that 'it cannot be too strongly emphasised that disease has no formal warning, it has no respect for persons, or for statutes ... and it cannot be explained or frightened away...'. <sup>3</sup> The *National*

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<sup>2</sup> Commonwealth of Australia, *National HIV/AIDS Strategy*, Canberra, Australian Government Publishing Service, 1989; Commonwealth of Australia, *National HIV/AIDS Strategy 1993-1994, 1995-1996*, Canberra, Australian Government Publishing Service, 1993.

<sup>3</sup> Health Department of Tasmania, *Public Health Annual Reports 1907*, at p. 1.

*HIV/AIDS Strategy* recognises this in its guiding statement which says that the law should complement and assist education and other public health measures. The Strategy lists a number of principles<sup>4</sup> and through the various chapters of this thesis these concerns have been indirectly considered. It is necessary to examine how successful Australia has been in adhering to some of these principles within the theme of this thesis.

It was suggested by the Strategy that 'law reform should take a rational, humane and responsive approach to the problems of the HIV epidemic'.<sup>5</sup> Interestingly, US writers in the area call for more effective prevention and health care strategies, which they believe can only be obtained by 'experiences and views of those hit hardest by the epidemic [being] made more central to the conduct of scientific research and the establishment of health policy'.<sup>6</sup> These authors admit that in the US there is a need to transform the approach to HIV. By contrast, the Australian response has been characterised by a mobilisation of efforts of the Commonwealth Government, the State government and community sectors. The code of success in Australia is the effective partnership between government, the medical/scientific community, affected communities and a political approach generally supported by all major parties.

In this respect one would expect a rational and responsible approach to the development of policies and legislation. But there are instances where the spirit of the Strategy is not being adhered to and there is also a need to realise that in the area of criminal justice there is very little guidance as to how the major institutions of criminal justice are to manage AIDS. Suspects in the criminal process and prisoners are still a much maligned group where irrational interests of others seem to predominate in policy development and day-to-day handling of these persons. There are examples from public health where legislation has been enacted that has not been informed and rational. For example, as reflected upon in chapter four, early AIDS-motivated health legislation which was operable in Queensland until 1988 had created a protective measures defences to a transmission offence for partners in long-standing relationships only. In addition, there is also the *Tasmanian HIV/AIDS Preventative Measures Act (1993)* which sets

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<sup>4</sup> *National HIV/AIDS Strategy 1993-1994, 1995-1996*, para. 6.0, at p. 38.

<sup>5</sup> *Ibid.*

<sup>6</sup> Fee, E., and Krieger, N., 'Understanding AIDS: Historical Interpretations and the Limits of Biomedical Individualism', *Am J of Pub Health*, 1993, 83/10:1477-1486, at p. 1483.

up a process for dealing with transmission, testing, counselling and education but potentially undermines the success of the legislation because the government frowns upon and the legislation prohibits homosexual conduct.

Another important guiding statement in the Strategy was that 'laws created to deal with HIV/AIDS alone require particular justification'.<sup>7</sup> In chapter two and three of this thesis it was recognised that as the criminal law intrudes into peoples lives and conflicts with their rights there must be some justification for this. Similarly, public health is one of the few areas where personal liberty can be restricted without commission of any criminal act. The insertion of new offences into criminal legislation in New South Wales and Victoria which were considered in chapter three, disregard the terms of the Strategy which were to limit interference in the criminal sphere not extend it. Chapter three reveals that the present application of these offences is following the pattern predicted; that they would be used to prosecute visible groups in the population. The Victorian *Crimes Act* endangerment provisions have been used to prosecute prostitutes in that State. Given that there is no documented case of HIV being transmitted by a prostitute in Australia this is counterproductive. Further, in 1992 Queensland increased penalties for prostitution and reimposed imprisonment as a remedy. As many prostitutes are IV drug users it is misguided to introduce these persons into prison environments. Imprisonment is not the appropriate response, counselling and education are. The Strategy recommended that States consider repealing legislation which specifically applies to homosexuals, prostitutes and drug users. Tasmania's continued criminalisation of homosexual activity is therefore against the spirit of the guidelines. There have been instances where suspects of crimes have been tested for HIV for a variety of purposes. The Strategy particularly recommended that an order needed to be obtained from a Magistrate to test an accused person for HIV. In only two States has legislation of this type been enacted. There appears to be a reluctance of legislatures to remedy the uncertainty discussed in chapter six of this thesis about the legality of testing blood samples for HIV by police to obtain evidence to substantiate the charge. Yet, in contrast, the issue of allowing one person to be tested for the benefit of another has been legislatively endorsed in specific circumstances in Tasmania and Victoria.

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<sup>7</sup> *supra* note 4.

The Strategy also stated that 'reform measures should be as uniform as possible, across the different jurisdictions'.<sup>8</sup> Legislators recognised the need for this early in the epidemic, but their response was not motivated by clear and rational thought but by public sentiment which lead to haphazard amendments, which in turn resulted in little uniformity between the States. This lack of uniformity was exemplified in chapter seven by a number of examples, including, inconsistent testing policies in Australian prisons and the little uniformity on protections against breaches of confidentiality where HIV testing schemes operate in prisons. Uniformity is still lacking in the area of public health with some States yet to make any amendment to out-of-date statutes. Not only do we have a lack of consistency, we have apathy in the less populace jurisdictions which again illustrates the importance of politics in the drive towards amendment.

It is true that since the development of the Strategy a clearer policy has been laid down which has been generally free from partisan approaches of the various political parties. All States and Territories should adapt and give effect to the spirit of the Strategy. There is evidence, that Australian governments generally are acting from a well-educated base in consulting with medical, social and legal experts in drafting and passing legislation. But there remains much to be done. Clarity and rationality must continue to guide policy and law-makers and those who put the policy and law into effect.

In the future there will be a number of duties imposed on particular groups and individuals. Governments, legislators and members of the judiciary have a duty to continue to be apprised of the variety of expert opinion available on preventing the spread of the virus with minimal impact on the lives of individuals infected with HIV. This applies whether the subject of any legal prohibition or procedure is a recalcitrant HIV carrier, an accused person, a victim, or a witness to a proceeding. For example, considerable thought needs to be given by legislators before the enact a HIV specific transmission offence or before statutes are enacted which permit one person to be tested for HIV for the benefit of another. Similarly, prosecutors need to consider the special problems presented by HIV-infection before acting to initiate cases of HIV transmission. Judicial officers need to decide under what circumstances non-custodial options could be more usefully applied to HIV-infected persons. In addition, some of the sentencing decisions in chapter six of this thesis reveal that judges need to be aware of the medical facts relating

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<sup>8</sup> *supra* note 4.

to the progression of HIV to AIDS. Competing circumstances must be weighed in each situation and more frequently courts are being called upon as arbiters to weigh these competing interests. Their role is growing in this regard as legislation requires that court orders be obtained for isolation, detention and testing. Applications for testing across a broad spectrum will require some researched analysis before they are ordered. Public health measures adopted to restrain persons acting to the detriment of community health during past epidemics of communicable diseases must be scrutinised before being applied to HIV-infected persons. If the overriding aim is the prevention of disease then criminal law and public health legislators must work together on a preventative policy.

Medical research reveals that HIV will be with us for a long time. During that time AIDS will resist legal sanction and continue to spread and kill. It has been apparent early in the course of the epidemic that we cannot expect the necessary solutions to come solely from scientists. It is incumbent upon legislators and court personnel to take what steps they can to inhibit the spread of the disease. Controlling the HIV epidemic and at the same time solving other problems will require different, mutually reinforcing techniques to reach the myriad of groups in our pluralistic society. Whether Australia's low cases of HIV in the community are the result of good management or good fortune will remain to be seen as we progress through this second decade of AIDS. The key will be in our ability to develop a culture of responsibility, to maintain the current position or correct it where necessary and to avoid either social or legal complacency in curbing the spread of HIV/AIDS.



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